

# Royal Brompton and Harefield NHS Foundation Trust

# Royal Brompton 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



Medical care

Outstanding



Surgery

Requires improvement



Critical care

Requires improvement



Services for children and young people

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis. The adult congenital heart disease unit was the first of its kind in Europe and remains the largest.

The organisation houses approximately 512 inpatient beds, of which 360 are general acute beds, 59 paediatric beds and 93 critical care beds. They deliver in the region of 38,619 inpatient admissions and 178,495 outpatient attendances.

The organisation delivers care across two hospital sites: the Royal Brompton Hospital site, Chelsea and the Harefield Hospital site. They employ in the region of 3,298 staff and have a financial revenue of £367.5 million, generating a financial deficit of £3.3 million during 2015/16.

The Royal Brompton site employs more than 2,200 staff. It has five dedicated operating theatres, one hybrid theatre and four catheter laboratories. The Royal Brompton hospital has 312 beds, including for:

- surgery
- intensive care
- respiratory
- cardiology
- paediatric
- paediatric intensive care patients.

Our key findings were as follows:

We rated the Royal Brompton hospital as requires improvement overall. This was because:

- There were failures in infection control practices. This included variable hand hygiene audit results, inconsistent nurse practice and inadequate handling of intravenous fluids.
- Systems, processes and standard operating procedures were not always reliable or appropriate to ensure cleanliness and safety of equipment and the environment in theatres.
- Risks to people who used the services were not always assessed, monitored and managed. National Early Warning Score (NEWS) charts were not always used appropriately to guide escalation of deteriorating patients.
- The World Health Organisation (WHO) five steps to safer surgery checklist was not fully embedded.
- Nurses on surgical wards did not understand the sepsis six pathway and were unclear of the triggers which would prompt initiation of the six steps.
- Some areas of the hospital were dark and cramped, and some of the beds in the bays were close together due to limited capacity.
- Space in the outpatients department was limited and insufficient to cope with the number of patients attending.
- Patients were not consistently treated in a timely manner and within national indicators.
- Staff satisfaction was mixed. A number of staff told us they felt bullied in their work place. Staff told us they did not always feel actively engaged in changes or empowered to speak up. Staff in surgery and theatres reported perceived bullying and harassment. A number of staff in the critical care service told us they felt unsupported.

However,

# Summary of findings

- The hospital had a positive incident reporting culture. There process for ensuring incidents were reported and investigated was embedded in practice. Staff were aware of their responsibilities to report incidents and staff knew about their responsibilities relating to duty of candour. Learning from incidents was shared among teams.
- Staff had access to all the equipment they needed to keep patients safe. Resuscitation equipment was checked daily.
- Medicines were largely stored and managed appropriately.
- The majority of staff were aware of the safeguarding procedures including action to take to protect children and adults. However, staff caring for children and young people in the recovery area were not trained to the required safeguarding training standards.
- There were high completion rates of mandatory training across the services.
- There were sufficient nursing and medical staff to provide safe care for patients.
- There were good processes to monitor patient outcomes and ensure that care was delivered in line with best practice.
- The hospital participated in national and local research. The quality of care was monitored through a programme of audits.
- The survival rate of patients who were treated with extracorporeal membrane oxygenation (ECMO) was higher than the international average measured by the Extracorporeal Life Support Organization.
- Nutrition and hydration were well managed and individualised to each patient.
- Patients had their pain regularly assessed and managed effectively.
- Staff were competent and supported to provide a good quality service to patients. Staff were skilled in their specialist area and were supported in their roles by ongoing specialist training and development opportunities. However, ward staff expressed a current need for further training and support around the care of dying patients.
- There was a strong culture of multidisciplinary team working involving a full range of health and social care professional and underpinned care and treatment.
- Although MCA and DoLs training was not mandatory, capacity and consent issues were well understood by staff and correct procedures were followed in relation to these.
- People using the services were treated with dignity and respect and felt involved in their care plans. Patients told us that they felt respected and cared for and had their choices and preferences listened and responded to in a timely manner.
- Feedback from patients and their relatives was consistently positive about the way staff treated them. There was a strong holistic, person-centred approach to providing care to patients.
- Services were planned to meet the needs of the population served by the hospital.
- Services were designed to meet the individual needs of patients including support for patients who had dementia or a learning disability.
- Many of the clinical services were well led with good governance and risk management processes to monitor and evaluate care and report performance back to staff and to the trust board.
- The hospital actively sought and responded to the views of the people using the service.

# Summary of findings

- There was clear evidence of innovative and outstanding practice that had won many national awards. Policies developed within the trust were being used nationally and internationally.

We saw several areas of outstanding practice including:

- The multidisciplinary working of the medicine services at the Royal Brompton Hospital offered both a clinical and holistic look at the patient's needs.
- All staff within the medical division at the Royal Brompton Hospital felt actively engaged by their leaders and spoke very highly of their managers.
- In the service for children and young people, SPRinT training has won National awards Delegates attend the training from all over the world. The training has been taught and has commenced at other hospitals nationally.
- There were continuous research programmes of note for cystic fibrosis which had international acclaim and use.

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

## **Importantly, the trust must:**

- The trust must ensure hand hygiene practices are rigidly followed by all staff at all times and that infection control practices are embedded in all clinical areas.
- The trust must ensure operating procedures are in place are reliable to ensure the cleanliness and safety of equipment in theatres.
- The trust must ensure patients at risk of deterioration are identified and escalated appropriately.

## **In addition the trust should:**

### **In the medicine service:**

- All medical wards should ensure that patient medical records are locked away.
- All medical wards should ensure corridors are free from clutter.

### **In the surgery service:**

- The hospital should ensure all staff who are involved in the care and treatment of children and young people are trained in level three safeguarding.
- The hospital should ensure the use of the World Health Organisation (WHO) five steps to safer surgery checklist is fully embedded and utilised appropriately by all staff.
- The hospital should ensure staff in theatres received adequate rest periods following on-call work.
- The hospital should ensure the nursing management in theatres is appropriate and effective in the way in which change is managed throughout the department ensuring that all staff feel valued and involved.

### **In the critical care service:**

- The hospital should ensure conversations with patients and relatives that involve them in care are carried out consistently and routinely and are documented.
- The hospital should ensure areas used to store medicines can be temperature-controlled and that this is monitored at least daily
- The hospital should ensure junior doctors have robust, structured support in place that enables them to develop professional and clinical competencies.

# Summary of findings

- The hospital should ensure new consultants receive an adequate induction.
- The hospital should ensure quality monitoring and risk management processes are accessible by all.

## **In the end of life care service:**

- The hospital should introduce further formal training in End of life care (EOLC) for staff across the hospital, including training in the use of syringe drivers.
- The hospital should train all porters annually in infection prevention and control and keep a formal record of this training.
- The hospital should devise and introduce a validated assessment tool to document care of patients at the end of life.
- The hospital should improve data collection methods surrounding issues relating to EOLC in order to enable benchmarking and audits.
- The hospital should improve seven-day access to specialist palliative care provision.
- The trust should consider introducing a lay member to the trust board with responsibility for EOLC.

## **In the outpatients and diagnostic imaging service:**

- The hospital should ensure all outpatients department clinics start at their published time, and consultants do not accept work commitments inside the hours specified in their job plans.
- The hospital should reduce the time patients spend waiting in the outpatient's waiting room.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Medical care

### Rating

Outstanding



### Why have we given this rating?

We rated the medical services at the Royal Brompton Hospital to be 'outstanding' overall.

- The nature of the diseases the service treats means that patients could be service users for years and even decades. This ongoing relationship was reflected in the 'family' feel of the division and was relayed back to us by patients, nurses, ward managers, consultants and members of the senior executive team.
- Feedback from patients and their relatives was consistently positive about the way staff treated them. There was a strong holistic, person-centred approach to providing care to patients.
- Staff were enthusiastic about the work they did. Consultants and senior service managers were 'proud' of the innovative care and research taking place at the hospital.
- The collaborative nature of the multidisciplinary workings was robust and the allied health professionals input into the care plan was outstanding.
- Staff were encouraged to raise concerns and report incidents and near misses. Learning from incidents was shared at ward meetings, Schwartz rounds and grand rounds.
- The clinical areas were all cleaned to a high standard by a domestic team who were proud to work at the trust.
- Staff levels were good and were reviewed each day to ensure that there was enough staff and the right skill mix to ensure effective patient care.
- People using the services were treated with dignity and respect and felt involved in their care plans. Patients informed us that they felt respected and cared for and had their choices and preferences listened and responded to in a timely manner.

# Summary of findings

- Several schemes took place within the trust to assist the social needs of the patient e.g. the Rb&hArts scheme. We observed a harp player on one of the wards, which patients responded to very positively.
- Best practice guidelines in relation to care and treatment were followed and the service was responsive to the needs of its patients.
- The service actively sought and responded to the views of the people using the service.
- Staff reported that their matrons, managers and department heads, supported them. We observed that staff and patients were engaged in the development of the service.
- The ward areas were well maintained and relatively free from clutter however, there were capacity issues. Staff on the wards felt as though there was not enough room for patients and these issues were highlighted on the trust risk register.

## Surgery

### Requires improvement



We rated the surgery service at The Royal Brompton Hospital as 'Requires Improvement'. This was because:

- Staff we spoke with were unaware of the systems, processes and standard operating procedures to ensure cleanliness and safety of equipment and the environment in theatres.
- Staff caring for children and young people in the recovery area were not trained to the required safeguarding training standards.
- Risks to people who used the services were not always assessed, monitored and managed. The World Health Organisation (WHO) five steps to safer surgery checklist was not fully embedded. National Early Warning Score (NEWS) charts were not always used appropriately to guide escalation.
- The on-call staffing rota in theatres meant staff were working excessively long hours without the required rest periods.
- Staff satisfaction was mixed. There were a number of staff who told us they felt bullied in their work place. Staff told us they did not always feel actively engaged in changes or empowered to speak up.

# Summary of findings

- Management structures in theatres were not yet working cohesively with different staff groups managed by different managers and staff told us there was little engagement with them to manage change.

However

- The trust had good processes for the reporting of and escalation of incidents.
- Staff were committed to learning from incidents. When incidents occurred, patients received a sincere and timely apology. We saw examples of actions in place to improve processes to prevent the same happening again.
- Staffing needs were based on the acuity of patients. There were adequate number of nurses in the surgical wards. Theatre vacancies were managed, using bank and agency staff.
- There was a good understanding of the duty of candour requirements. Staff were able to give us examples where they had implemented these, alongside support from senior staff.
- There were high completion rates of mandatory training across the services.
- We saw that care and treatment was coordinated with other services and other providers. There were innovative approaches to providing integrated person-centred pathways of care, particularly for people with multiple complex health needs.
- There were good patient outcomes across the surgery services in both the heart and lung divisions.
- Feedback from patients who used the service and those close to them was consistently positive. People thought that staff went the extra mile and the care they received exceeded their expectations.

## Critical care

Requires improvement



Overall, we rated critical care at the Royal Brompton Hospital as requires improvement because:

- Incident reporting was embedded into the culture and practice of critical care and there was some



# Summary of findings

evidence of learning from this. However, not all clinical staff we spoke with were confident in the process or felt incidents they reported were dealt with appropriately.

- There were failures in local infection control effectiveness. This included variable hand hygiene audit results, inconsistent nurse practice and inadequate handling of intravenous fluids.
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- The hospital did not have a critical care outreach team. A similar service was in development through the creation of night practitioner roles for senior nurses and daily ward 'sweeps' conducted by the high dependency unit (HDU) matron and other nurses.
- Significant changes in management and communication from the senior team in the AICU had resulted in problems with staff morale. There was very limited evidence the senior team had the experience, ability or inclination to address this and 13 individual members of staff told us they felt very unsupported in the unit. Clinical governance was evident but had failed to address on-going staffing concerns.
- The supervision and opportunities for development and training of junior doctors had deteriorated because nine consultants had departed the AICU in a short space of time.
- Medicines were stored securely but the temperature of the AICU meant ambient medicines were stored above the safe maximum temperature recommended by the manufacturer.

## However:

- Nurse and medical staffing levels consistently met the requirements of the Royal College of Nursing and the Faculty of Intensive Care Medicine.
- Safeguarding practices ensured patients and their relatives were kept safe from harm, including from abuse and exploitation.
- There was a good track record in providing harm-free care, including in the avoidance of falls, urinary tract infections and pressure ulcers.

# Summary of findings

- The number of nurses with a post-registration qualification in intensive care medicine exceeded the minimum requirement of the Royal College of Nursing.
- Care and treatment was provided in line with national and international best practice guidance. Critical care services were working towards more robust national benchmarking.
- Outcomes for patients who were treated with extracorporeal membrane oxygenation were significantly better than international averages.
- Patients and relatives said they felt staff were compassionate and very caring.
- A dedicated team of clinical educators was highly regarded by staff and provided on-going teaching and learning opportunities, including through the use of simulation technology.
- Staff were given opportunities to develop professionally, including through leadership pathways and participation in quality improvement work.
- Support and services were available for patients with dementia, learning disabilities and communication needs, including translation. A range of multidisciplinary specialties were available, including physiotherapy, dietetics, occupational therapy, pharmacy, psychology and microbiology.

## Services for children and young people

Good



Overall we found the service for children and young people at Royal Brompton and Harefield Hospital as good because;

- The service had a robust process for ensuring incidents were reported and investigated. All staff were aware of their responsibilities to report incidents and staff knew about the duty of candour. The service had a positive incident reporting culture and staff received training sessions to learn from these. Learning from incidents was shared among teams.

# Summary of findings

- There was clear evidence of innovative and outstanding practice that had won many national awards. Policies developed within the trust were being used nationally and internationally.
- The paediatric service was caring. Staff treated children with care and compassion. We received positive feedback from all of the children and parents we spoke with. We were told that staff demonstrated a caring attitude and went beyond the call of duty to ensure both children and their family members received the best possible care.
- Patient's privacy and dignity was maintained throughout their hospital stay. Staff ensured that children and their families were told about their care and were fully involved in any treatment decisions. Consent to care and treatment was obtained in line with legislation and guidance.
- The service was effective. There were good processes to monitor patient outcomes and ensure that care was delivered in line with best practice. Ward staff worked well together to manage patients' pain. Staff on the wards monitored patients' nutrition and hydration and requested advice from a dietitian when required.
- Children and younger people's individual needs were taken in to account and an excellent multidisciplinary approach was taken when delivering care and treatment.
- Every member of staff that we spoke with was passionate about providing the best care possible. There was an open culture and staff felt valued and well supported from the leaders within this department and the wider board.

## End of life care

Good



We rated this service as 'good' because:

- There was an open and transparent culture across the trust, where staff felt comfortable to express their views and approach managers with their concerns. Learning from incidents and complaints were shared across the specialist team and the trust, now that data had been coded in such a way to allow this.

# Summary of findings

- The environment and equipment in both the hospital wards and the mortuary was suitable for purpose. Infection prevention control (IPC) measures were followed by staff from the mortuary, specialist teams and whilst we observed care on the wards.
- Patient care records and risk assessments were appropriate, thorough and complete. They considered different treatment options and showed clear involvement of patient and relatives in treatment decisions. Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient. Individuals with complex needs were recognised and their care was tailored by the service.
- Capacity and consent issues were well understood by staff and correct procedures were followed in relation to these. Some issues around the completion of do not attempt coronary pulmonary resuscitation (DNACPR) forms had been picked up and were being addressed.
- There were enough specialist nurses on the palliative care team to enable them to see all patients on their caseload. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- A multidisciplinary team approach was evident both across the specialist team and across the hospital. Patients at the end of life were cared for compassionately and holistically, with input from psychology, chaplaincy, physiotherapists and other allied health professionals (AHPs) as necessary. The needs of relatives were also considered and addressed by the wards, specialist team and dedicated bereavement service.
- A recently developed EOLC strategy aimed to ensure that the specialist team were able to support other staff even further in the event of death. A detailed educational strategy was in place and due to be rolled out to ensure staff across the trust felt confident with caring for patients at the end of life. Regular meetings and

# Summary of findings

forums took place that addressed issues in EOLC with various stakeholders. This included a specific EOLC steering group that met quarterly to discuss any issues specific to EOLC.

However:

- Despite the intention to introduce an educational plan, there were some existing issues with staff education and training at the time of the inspection. Ward staff expressed a current need for further training and support around the care of dying patients. Porters were broadly unaware of the procedures to follow in terms of IPC and there were no existing training records for porters at the Royal Brompton site. Despite a recent incident relating to the use of syringe drivers, only 47% of ward nursing staff had been trained in this competency.
- The trust had not introduced a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.
- Data collection for issues relating to EOLC was currently an issue, limiting the amount of audit activity that the specialist team could take part in and use to improve patient outcomes.
- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This is contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week. There was only specialist consultant presence on site at the Royal Brompton hospital one day per week, limiting face-to-face contact with patients.
- There was no lay member with responsibility for EOLC on the trust board.

## Outpatients and diagnostic imaging

Good



We rated the service overall as Good because:

- There was a strong culture of reporting and learning from incidents. Incidents were

# Summary of findings

discussed at staff meetings and clinical governance training events. Action was taken to reduce the likelihood of similar incidents occurring in the future.

- The number of (IRMER) incidents reported was higher in 2015 than the previous year. This had been investigated and improved reporting was demonstrated to be the main reason for the increase.
- Equipment in diagnostic imaging was well maintained with rolling programmes of servicing and checks.
- Hand hygiene audits in diagnostic imaging departments showed high levels of compliance
- Medicines were stored safely and patients were able to collect their prescriptions after their appointment from the pharmacy adjacent to the outpatient department.
- Clinical support assistants were trained and supervised by registered nurses to carry out a range of tests in advance of patients seeing their consultant.
- The outpatient and diagnostic imaging departments provided an effective service based on national good practice guidance and evidence based guidelines.
- There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions that had a positive impact on outcomes for patients.
- Clinical support staff were trained and supervised by registered nurses to provide a range of patients tests so that the results were available for the patients appointment with their consultant.
- Staff were competent and supported to provide a good quality service to patients. Staff were skilled in their specialist area and were supported in their roles by ongoing specialist training and development opportunities.

# Summary of findings

- There were effective multi-disciplinary teams in place within the hospital and links with specialists from other trusts.
- Audits were carried out in CT and other diagnostic imaging services which reviewed practice against guidelines and set goals for improvement
- All the patients we spoke with told us they felt as if they were treated as individuals. Many patients had visited the hospital regularly for several years and told us they knew staff well and always felt supported.
- Services supported patients to self-manage their care where possible helping them to retain their independence and reduce the number of times they had to travel to the hospital.
- Staff considered patient's personal circumstances when organising care and organised counselling to support patients.
- Patients emotional and psychological needs were assessed as part of the treatment process.
- Patients told us they received instructions with their appointment letters and were given written information as needed.
- Appointments between outpatients and diagnostics were co-ordinated to allow patients to have diagnostic procedures whilst waiting for consultation minimising the time that patients spent in hospital.
- Staff described how patients in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required.
- Long term patients were given an emergency number to contact if they needed to be seen urgently and could be seen on weekends on the ward by medical cover staff.
- Radiology had slots available to urgently accommodate patients travelling long distances avoiding them making multiple journeys.

# Summary of findings

- The trust met the national standard for referral to treatment rates each month for non-admitted pathways between April 2015 and March 2016 with the exception of October 2015.
- The trust consistently exceeded the target for cancer patients to be seen by a specialist within two weeks of urgent GP referral between quarter 3 of 2013/14 and quarter 2 of 2015/16 aside from quarter 1 of 2014/15 and to receive first definitive treatment within 31 days of diagnosis.
- The percentage of diagnostic waiting times over six weeks was consistently lower than the England average between October 2013 and January 2016 with the exception of July 2015.
- There were clear governance and risk management processes in place.
- Staff in diagnostic imaging felt they contributed to improvements at work.
- The results of the 2015 staff opinion survey by staff group showed radiology scores for staff engagement were higher for radiology staff than many other clinical teams in the trust.
- Staff in outpatients and diagnostic imaging spoke highly of the trust's leadership who were visible throughout the Royal Brompton departments.

However,

- The trust consistently breached the target for patients to wait less than 62 days from urgent GP referral to starting treatment between quarter 3 of 2013/14 and quarter 2 of 2015/16. The trust was not actively working with referring trusts to improve pathways and referral times
- We were told the service did not record the time patients arrived in clinic, so waiting times were not routinely monitored.
- The Brompton outpatient service risk register highlighted that patients had to wait for longer than 12 months to be seen in the adult congenital heart disease clinics. The service was



## Summary of findings

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unable to see patients who had been referred. Patients often became unwell before they could be seen in clinic and there were problems reviewing follow up patients who had received their surgery.

- Figures provided by the trust showed 27% of clinics started late for the period April 2015-March 2016.
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# Royal Brompton Hospital

## Detailed findings

### Services we looked at

Medical care, Surgery; Critical care; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

# Detailed findings

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## Background to Royal Brompton Hospital

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis. The adult congenital heart disease unit was the first of its kind in Europe and remains the largest.

The organisation houses approximately 512 inpatient beds, of which 360 are general acute beds, 59 paediatric beds and 93 critical care beds. They deliver in the region of 38,619 inpatient admissions and 178,495 outpatient attendances.

The organisation delivers care across two hospital sites: the Royal Brompton Hospital site, Chelsea and the Harefield Hospital site. They employ in the region of 3,298 staff and have a financial revenue of £367.5 million, generating a financial deficit of £3.3 million during 2015/16.

The organisation has a stable executive and nonexecutive leadership team, led by Chair Neil Lerner and Robert Bell, CEO of eleven years. Two members of the Executive team, took up post within 12 months prior to inspection, including the Director of Nursing and the Interim Medical Director.

The trusts vision and mission is to be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.

The trust provides the following services:

- Cardiology
- Cardiothoracic surgery
- Cardio-respiratory critical care services for adults and children
- Children's & Adolescent services
- Lung cancer service
- Respiratory medicine

We inspected The Royal Brompton and Harefield NHS Foundation Trust, including the seven core services: Medicine, Surgery, Critical Care, Services for children and Young People, Outpatients and diagnostic services and End of Life Care services.

# Detailed findings

## Our inspection team

Our inspection team was led by Chair: Dr Nick Bishop, Non-Executive Director, Great Western Hospitals NHS Foundation Trust

Team Leader: Nicola Wise, Head of Hospital Inspection, Care Quality Commission

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists. This was comprised of consultants in: cardiovascular, cardiothoracic surgery, critical care, paediatric

respiratory medicine, paediatric critical care, palliative care, Cardiac Physiology and Radiology. The team also comprised of nurses with backgrounds in cardiothoracic medicine, cardiothoracic theatres, paediatric critical care, paediatric respiratory care, general paediatric and palliative care. The team also included cardiothoracic technicians, and specialist advisors with board-level experience, safeguarding specialists and two experts by experience.

## How we carried out this inspection

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

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

The inspection team inspected the following core services:

- Medicine
- Surgery
- Critical Care
- Services for children and young people
- Outpatients and diagnostic imaging
- End of Life Care

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 Improvement, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We considered in full information submitted to the CQC from members of the public, including notifications of concern and safeguarding matters.

Members of the public spoke with us at our open days held at the trust on 7 and 9 June 2016.

We held focus group discussions with separate groups of staff. Participants included: allied health professional, administration and clerical staff, band 5 and 6 nurses, senior sisters and charge nurses, matrons and clinical nurse specialists, consultants, junior doctors and members of staff at different grades from black and ethnic minorities.

We also interviewed senior members of staff at the trust.

Our announced inspection visit took place over 14, 15 and 16 June 2016. We also undertook a further unannounced visit on 26 June 2016.

## Facts and data about Royal Brompton Hospital

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to

# Detailed findings

Europe's largest centre for the treatment and management of cystic fibrosis. The adult congenital heart disease unit was the first of its kind in Europe and remains the largest.

As a tertiary service it also provides services to a much wider population, as well as for overseas patients.

## Key figures

**Beds:** The trust houses a total of 512 beds; of which 360 are general and acute beds; 59 are allocated children's beds and 93 are classed as critical care beds.

**Staff:** At the time of inspection the trust employed 3298 whole time equivalent (WTE) staff, of which 491 are medical, 1376 are categorised as nursing and 1431 are categorised as 'Other.'

**Financial:** The trust had a revenue of £367,510,769, with a full Cost: £370,828,291. This resulted in a reported deficit of £3,317,522.

**Activity (Acute):** The trust reported 38,619 inpatient admissions and 178,495 outpatient attendances in 2014/15.

**Deprivation:** Out of 326 authorities, Kensington and Chelsea is ranked 84th most deprived authority in England. In the 2015 Indices of Multiple Deprivation, Kensington and Chelsea Unitary Authorities ranked in the second quartile for deprivation.

Out of 326 authorities, Hillingdon is ranked 200th most deprived authority in England. In the 2015 Indices of Multiple Deprivation Hillingdon is in the third quartile for deprivation.

**Key intelligence indicators** (this data was provided at trust level)

## Safe

- The trust reported one never event (relating to surgical procedures) was reported from March 2015 to March 2016.
- The trust had 25 serious incidents requiring reporting and investigating via the Strategic Executive Information System (STEIS). The majority of these related to pressure ulcers and surgical/invasive procedures.
- The trust reported 16 incidents via the National Reporting and Learning System (NRLS) in the same period, which was better than the England average.

- No cases of MRSA were reported for the period February 2015 to January 2016
- There were no reported cases of Meticillin Resistant Staphylococcus Aureus (MRSA) for the period February 2015 to January 2016
- The trust reported 22 cases of C.Diff for the period January 2015 to January 2016, but numbers remained below the England average from July 15 to January 2016.
- Eight cases of MSSA were reported but with the exception of December 2015, numbers were below the England average
- The proportion of registrars employed by the trust was higher than the England average. The proportion of middle career and junior doctors were lower than the England average and the proportion of consultants was in line with England averages.

## Effective

- The trust had one elevated risk for the Composite indicator: In-hospital mortality - Cardiological conditions and procedures.

## Caring

- The trust was in the top 20% of trusts for eight of the 34 questions and in the bottom 20% for nine questions in the Cancer patients Experience Survey.
- Performance was mostly in line with England averages in the Patient Led assessment of the Care Environment 2015
- The trust performed better than the England for four of the 12 questions in the CQC Inpatient Survey 2014 and in line with other trusts for the remainder of questions
- Performance in the Friends and Family Test was consistently better than the England average from March 2015 to March 2016.

## Responsive

- Between April 2013 and August 2015 the majority of delayed transfer of care were due to completion of assessments (35.1%), and awaiting further NHS non-acute care. Both were higher than the England average of 18.5% and 20.2% respectively
- Bed occupancy has varied between quarter two 2013/14 to quarter three 2015/16 and was above the England

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average on three occasions before quarter three 2013/14 and then again in quarter four 14/15. Most recently it has been below the England average. (This data reflects overnight bed usage only).

- The trust received 80 written complaints in 2014/15, an increase of 15 written complaints from 2013/14. From quarter one to quarter three in 2015/16 the trust received 70 written complaints.

## Well Led

- The sickness and absence rate varied between approximately 2.5% and 2.2% between January 2013 to January 2015. The sickness rate was consistently better than the England average throughout this period

- In the General Medical Council National Training Scheme Survey the trust scored within expectations for all 14 indicators.
- In the 2015 Staff survey the trust scored in the top 20% of all trusts for 18 and in the bottom 20% for five of the 32 questions.

## Inspection history







- The Royal Brompton hospital was inspected in February and August 2013 and was compliant with the standards and regulations we inspected against at that time.

## Our ratings for this hospital

Our ratings for this hospital are:

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

# Medical care

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

## Information about the service

The Royal Brompton and Harefield NHS Foundation Trust is a specialist heart and lung hospital known both locally and internationally as a treatment centre for people with heart and lung disease. Medical services at the Royal Brompton Hospital in Chelsea include five inpatient wards and four catheter laboratories.

Medical services at the Royal Brompton Hospital in Chelsea are delivered across two divisions:

1. Heart division
2. Lung division

These divisions are spread across five wards at the Chelsea site. These wards are: Foulis ward, Lind ward, Victoria ward, Paul Wood ward and York ward. We visited these wards during our inspection.

Foulis ward specialises in care for patients with cystic fibrosis and bronchiectasis. The ward has 35 beds divided into 28 single rooms, a three bed bay and a four bed bay. All rooms have their own en-suite facilities.

Lind ward specialises in the care of patients with all types of respiratory conditions, including pulmonary fibrosis, difficult asthma, cystic fibrosis (CF) and bronchiectasis. There are 12 beds. The ward also has a day unit, a short stay ward and the Jane Gray bronchoscopy suite.

Victoria ward treats and cares for patients with acute respiratory conditions. The ward has 26 beds and four High Dependency Unit (HDU) beds.

Paul Wood ward is a mixed cardiology and cardiac surgery unit, which is dedicated to the care of patients with adult congenital heart disease (ACHD) and patients undergoing investigations for other cardiac related diseases. The ward has 31 beds separated into bays and each bay is single-sex.

York ward cares for patients who require treatment for a wide range of cardiac problems. The ward has 34 beds.

We also visited the sleep ward and four catheter laboratories and spoke with members of staff that performed procedures in the labs.

We reviewed eight patient records and prescription charts. We spoke with four family members, 12 patients and 35 members of staff including nurses, doctors, ward managers, practice educators, physiotherapists, pharmacists, student nurses, healthcare assistants and domestic workers. We also spoke with the senior managers who were responsible for various services.

# Medical care

## Summary of findings

We rated the medical services at the Royal Brompton Hospital to be 'outstanding' overall.

- The nature of the diseases the service treats means that patients could be service users for years and even decades. This ongoing relationship was reflected in the 'family' feel of the division and was relayed back to us by patients, nurses, ward managers, consultants and members of the senior executive team.
- Feedback from patients and their relatives was consistently positive about the way staff treated them. There was a strong holistic, person-centred approach to providing care to patients.
- Staff were enthusiastic about the work they did. Consultants and senior service managers were 'proud' of the innovative care and research taking place at the hospital.
- The collaborative nature of the multidisciplinary workings was robust and the allied health professionals input into the care plan was outstanding.
- Staff were encouraged to raise concerns and report incidents and near misses. Learning from incidents was shared at ward meetings, Schwartz rounds and grand rounds.
- The clinical areas were all cleaned to a high standard by a domestic team who were proud to work at the trust.
- Staff levels were good and were reviewed each day to ensure that there was enough staff and the right skill mix to ensure effective patient care.
- People using the services were treated with dignity and respect and felt involved in their care plans. Patients informed us that they felt respected and cared for and had their choices and preferences listened and responded to in a timely manner.
- Several schemes took place within the trust to assist the social needs of the patient e.g. the Rb&hArts scheme. We observed a harp player on one of the wards, which patients responded to very positively.

- Best practice guidelines in relation to care and treatment were followed and the service was responsive to the needs of its patients.
- The service actively sought and responded to the views of the people using the service.
- Staff reported that their matrons, managers and department heads, supported them. We observed that staff and patients were engaged in the development of the service.
- The ward areas were well maintained and relatively free from clutter however, there were capacity issues. Staff on the wards felt as though there was not enough room for patients and these issues were highlighted on the trust risk register.



# Medical care

## Are medical care services safe?

Good



We rated safe as good because:

- The service had a robust process for ensuring that clinical incidents were reported and investigated. Staff were aware of their responsibilities to report incidents and were open with patients when things went wrong. There were a range of forums and learning events for staff to receive feedback and learning from reported incidents.
- Risk assessments took place in order to identify and manage patient risk. The wards took measures to ensure that patients at risk of falls were appropriately cared for.
- The measures for the prevention and control of infection met national guidelines and the standards of hand washing were consistently high across the wards. Although cramped all the wards and clinical areas we observed were cleaned to a high standard.
- Although some of the wards had struggled with employing band 6 nurses, we observed staffing levels to be good. Staffing levels were tracked throughout the day and nursing staff would be moved across the division as needed. Staff would be moved to different wards according to need and agency or bank staff were used to ensure safe staffing levels.
- The introduction of the electronic prescription system had reduced the number of medication related incidents and promoted the safe prescription and administration of medication. Controlled drugs were all locked in cupboards and checks were always completed.
- A scoring system known as the national early warning score (NEWS) was used to identify patients who were at risk of deteriorating. Staff were aware of the processes in place to ensure an appropriate and timely response when patients were deteriorating. This system was used well by all staff.

However:

- The environment on some wards was somewhat cramped and the building was old and dated. The patient beds in some bays were close to one another.

- Compliance with some mandatory training topics were below the trust target of 75%.
- Antibacterial hand gel, although present on wards was not obvious and we observed family members entering clinical areas without a clear reminder that antibacterial hand gel was necessary.

### Incidents

- Staff we spoke with were aware of how to report incidents and the processes around escalating incidents to senior staff. Incidents were reported through the trust's electronic reporting system.
- No never events were reported from March 2015 to February 2016. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- From June 2015 to May 2016, medical services reported 544 incidents that were reported via the trust incident reporting system. Over 60% were classed as a near miss and resulted in low or no harm to the patient. The most common incidents reported related to issues with medication for example, medication errors.
- From March 2015 to February 2016 there were seven serious incidents requiring investigation of which, two were attributed to slip-trips and falls. We saw a sample of Root Cause Analysis' (RCA's) for these incidents and found that they were well considered and thorough. Learning from these was disseminated to all staff.
- Senior staff told us that feedback on patient safety and learning from incidents was discussed at daily safety briefings as well as weekly ward meetings.
- Grand rounds took place every week and learning from incidents was one of the topics often talked about. Grand rounds are formal meetings for doctors with clinical nurse specialists and nurses in attendance. The objective was to discuss issues and learning.
- Mortality and Morbidity meeting (M&Ms) were held every month and were well attended by doctors and consultants. We observed M&M minutes, which showed that the management of patients was scrutinised, action points were discussed and lessons learnt were identified.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

# Medical care

health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

- The majority of staff we spoke to were not familiar with the term 'duty of candour'. However, when asked what they would do if something went wrong, all staff described the importance of being open and honest. All staff were aware that the patients and their families had a right to receive open and transparent care.
- Senior staff were aware of the duty of candour legislation and were aware of the trust's duty of candour policy.
- Staff were able to outline the process of escalation when things went wrong.

## Safety thermometer

- The NHS safety thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- From March 2015 to February 2016, there were 19 pressure ulcers, three falls with harm and three catheter acquired urinary tract infections (C.UTI's) reported.
- On some wards, there had been issues with a high prevalence of falls. Where this was the case there were appropriate safeguards put in place to minimise the amount of falls on the ward. Patients who were at risk of falls were given anti-slip socks and nurses monitored them closely on intentional rounding.
- On respiratory wards, there was a small number of pressure ulcers on the face in patients with ventilation masks. This was managed by strong input of the tissue viability team and nursing groups that worked closely with the team.
- There were concerns of pressure ulcers on the respiratory wards as patients could be immobile due to their respiratory disorder. Waterlow risk assessments were completed weekly to guide care and pressure areas were checked frequently. At the entrance to the wards, there were dashboards to display safety thermometer data.

## Cleanliness, infection control and hygiene

- Throughout clinical areas, we found that wards and departments were clean and tidy. We observed domestic staff cleaning throughout the day and saw cleaning checklists that were up to date and signed with no omissions.
- We observed staff using anti-bacterial hand gel and washing their hands in line with trust policy. Adequate supplies of personal protective equipment (PPE) were available. We observed some staff using PPE before coming into contact with patients who were at risk of infection due to weak immune systems. Although all clinical areas had anti-bacterial hand gel, we found that they were not always obvious or clear to see.
- Immuno-compromised patients were placed in isolation in side rooms to minimise risk of infection. There were clear signs outside the rooms of patients who were at risk of infection as well as information on the precautions to be taken when entering a side room.
- Wards and clinical areas used green 'I am clean' stickers to notify staff the area had been cleaned within the last 24 hours and was ready for use.
- We observed cleaning staff sticking to rota's and were on hand if staff needed extra cleaning at any time.
- Audits on hand hygiene were carried out monthly in all medical areas. From October 2015 to December 2015 the wards compliance with hand hygiene were between 81% and 100%. The trust target for hand hygiene compliance was 90% and over.
- Nursing staff throughout the medical division had 100% compliance with the trust bare below the elbows policy. From October to December 2015, York ward compliance with bare below the elbows was 89%. This was below the trust target of 100%.
- High risk patients were screened for meticillin-resistant staphylococcus aureus (MRSA). MRSA is a bacteria that can be present on the skin and can cause serious infection. MRSA patients were cared for in side rooms until they had three consecutive swabs that were negative. From April 2015 to March 2016 there had been no cases of MRSA throughout the medical service.
- Patients with suspected clostridium difficile (C.Diff) were cared for in a single room with their own toilet facilities. C.Diff is a bacterium that can infect the bowel and cause diarrhea and most commonly affects those people who have been recently treated with antibiotics. From April 2015 to March 2016 there had been five cases of C.Diff throughout the medical wards.

# Medical care

- Patients who were in single rooms due to infection would have a notice kept on the front of their door. Those patients were instructed about the importance of maintaining good hand hygiene practice. Clinical staff would have to wear personal protective equipment (PPE) including disposable gloves and aprons when coming into contact with patient in isolation. Throughout the inspection we observed this practice taking.
- All sluice rooms were clean and well maintained and the staff and patients spoke highly of the domestic staff who kept the clinical areas clean and tidy.
- We reviewed a commode cleaning record, which was up to date and fully completed. We also looked at the trust proforma for 'hygiene code daily checklist'. This was a list of ways that staff could ensure good hygiene practices. This was used for audit purpose and was fully completed. .
- Infection, Prevention and Control (IPC) training formed part of the mandatory training program that was updated yearly. The trust's target was 75% of staff having completed the training, within the medical service 68% of staff had completed this training.
- Some equipment on the sleep wards within the respiratory division did not display PAT labels and a sleep technician could not provide an answer as to how often the machines were tested.
- Respiratory wards stocked portable oxygen tanks at the reception. These were used to transfer patients around the hospital when needed. The senior nurse on duty checked the bottles daily to ensure they were full and ready to use. .
- A hand cleanliness audit machine assessed the effectiveness of an individual wash and summarised the data for audit purposes.
- There were sharps bins located in all treatment rooms that complied with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
- Health and safety was part of the statutory training program which staff were required to attend. The trust's target was for 75% of staff to have completed the training. Within the medical service 89% of staff had completed the training.

## Medicines

### Environment and equipment

- The four catheter laboratories (cath labs) were well lit and clean. The equipment we looked at had registration stickers and appropriate inspection labels.
- All clinical areas were bright and clean. However, there was a degree of clutter in the medical division due to a general lack of space. The restriction of the environment was on the risk register.
- Each clinical area had resuscitation equipment centrally located and readily available. There were systems in place to ensure that equipment was checked daily and staff took responsibility of this as well as regularly auditing the process of checks had been completed .
- On the respiratory ward, we saw a difficult airway intubation trolley that was checked regularly in line with trust policy. However, we found there was only one trolley between three wards.
- We saw that the majority of Electrical Medical Equipment (EME) had a registration sticker and was serviced in accordance with recommendations. The Portable Appliance Testing (PAT) labels were attached to non-clinical electrical systems showing that they had been inspected and were safe to use.
- Over 50% of incidents within the medical division involved medication errors. The wards and clinical areas were learning and changing practice to ensure that patients were provided with the right medication.
- Examples of changes in practice included the patient being asked to tell staff their name and date of birth prior to receiving their unique ID wristband and the patient being asked the same details again prior to receiving medication. We observed medication rounds throughout the wards and witnessed nurses asking patients for these details before administering medication.
- The recent switch from paper to electronic prescriptions had also assisted in the reduction of medication errors and staff were happy with the new system. It had also increased accountability as staff as each staff member used an individual logon when administering medicines.
- Patients medications were kept in lockable cupboards which were by each patient's bedside.
- Treatment rooms throughout the heart and lung division were only accessible to staff with either a code or a swipe card. Controlled drugs (CD) were kept within locked treatment rooms and were locked away in separate cupboards.

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- On Paul Wood ward, the CD cupboard was not kept in a locked room. They were instead kept in a lockable cabinet by each bedside.
- We found medicine fridges were locked and fridge temperatures were checked daily. Fridge temperature logs we looked at were fully completed without omissions and all recoded temperatures were within the recommended range.
- The trust pharmacy team worked closely with all wards. On the cardiology wards, pharmacists were present twice a day and would go round and speak to patients about the medicines they were receiving and ensure the dosages were correct.
- Four pharmacists covered the respiratory wards and visits included morning and evening Monday to Friday and Saturday morning. In addition, pharmacy technicians checked ward stocks and reviewed new patients on the wards.
- The pharmacy was closed on Sundays however; there were two on call pharmacists available out of hours if needed.
- There were specialist pharmacists on the respiratory wards. In addition, a pharmacy technician checked ward stocks and reviewed new patients on the wards.
- The ward pharmacist reviewed electronic drug charts and began the discharge planning process three days before a planned discharge to ensure medication was ready.
- Medicines were available to order out of hours. If a medicine was unavailable on the ward staff knew the process to follow if they needed to order and access medication out of hours.
- There were medicine management link nurses on the cardiology wards who would look at incidents regarding medication errors and report back to the nurses at monthly ward meetings when learning or improvement were required.
- The electronic prescription system had effectively reduced medication errors. We observed the prescription charts and noted that it was not possible to advance to the next stage of the prescription process without checking e.g. name, allergies and date of birth.
- The nurses stated “although the electronic prescription system took some getting used to it is the most effective way to prescribe medicines”. They told us it was quicker to access prescriptions as doctors were able to log on

and prescribe remotely they told us that they no longer even require the doctor on the ward to prescribe the medicine; they can call the doctor in charge who can log on remotely wherever they are and prescribe.

## Records

- Over the course of the inspection, we reviewed eight medical records and found that patient notes were fully completed. Patient records contained a range of risk assessments including; pressure assessment within six hours of admission, Venous Thromboembolism (VTE) checks, nutritional and falls risk assessment.
- Throughout the medical division, the medical and nursing records were paper based and the prescription charts were electronic on the trust electronic prescribing and medicine administration (EPMA) system.
- We observed several computers on the wards with some on trolleys. Staff members had unique logins to access patient records on EPR to ensure accountability.
- Throughout the wards, paper based medical records were stored either on unlocked trays or at the nurses station. We saw no evidence of the medical records being locked away.
- Medical records on Victoria ward were all kept in a large office manned by medical staff, nurses and therapists. The room was locked and required a keypad code for access.
- There was a confidential waste bin located on all wards.
- Audits on nursing documentation were carried out weekly on Paul Wood ward.
- Information Governance was part of the mandatory training programme that all staff were required to attend. The trust’s target was 75% of staff having completed the training, within the medical service 89% of staff had attended training.

## Safeguarding

- The trust had a policy for the safeguarding of adults and children in place at the time of the inspection. The policy was located on the trust intranet and the staff we spoke to were aware of how to locate it and the team to call if they had further queries.
- Safeguarding protocols were in place for staff to follow if they had concerns and staff were able to explain the escalation process if they had concerns. All nursing staff were able to explain the escalation process if they had

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concerns about safeguarding. Nurses told us that they received feedback from safeguarding referrals and learning from those referrals took place at monthly ward meetings.

- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. The trust's training target was 75% of staff having completed their training. 97% of staff had completed safeguarding children level 2.

## Mandatory training

- The trust mandatory training programme included medical gas, basic life support and manual handling training. The trust target for compliance with mandatory training was 75%.
- At the time of our inspection, 73% of staff were up to date on their mandatory training. Some areas routinely fell below the trust target. For example, for infection control, only 68% of staff had completed the training and only 55% of staff had undertaken their medicines management training.
- All wards had practice educators who could assist and facilitate further learning at the request of ward staff. It was the role of the practice educator to ensure that all staff were up to date with mandatory training and would inform staff via email if their mandatory training update were due.
- The trust benefitted from an online learning management system that staff could access to see a list of mandatory and additional training sessions available. It also informed staff when their training was due to be renewed.
- Every new member of staff had to complete training on the electronic patient records (EPR) system within two weeks of commencing employment at the trust. Staff would not receive an EPR password until the training was completed.

## Assessing and responding to patient risk

- A National Early Warning Score (NEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This is a basic set of observations such as respiratory rate, oxygen saturation, temperature and heart rate. This was all monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-patients in Hospital'.
- There were five HDU beds located on Victoria ward for patients who required level 2 nursing care.

- For patients at risk of falls, there was a risk assessment in place in the integrated care pathway documentation. This would assess the patients risk based on a variety of factors including the patient history of falls, confusion and patient age. The staff also filled out a bedrails screening tool in order to avoid patient falls.
- Staff in the cath labs utilised the World Health Organisation (WHO) safety checklist for every patient. The WHO checklist is used to ensure patient safety throughout the perioperative journey.
- Adult basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 75% of nursing staff having completed the training; within the medicine service 89% of nursing had attended the training.

## Nursing staffing

- Whilst on inspection we observed that all medical wards had adequate nursing staff in place. All wards displayed easy to understand nurse staff information on patient facing dashboards in line with guidance contained in the Department of Health document 'hard choices'.
- The tool used to support the nursing establishment review within the Trust was the Safer Nursing Care Tool (SNCT) developed by the Shelford Group.
- The service had increased qualified nursing levels on the wards in line with the National Institute of Health and Care Excellence (NICE) guidance. The cardiology wards had recently launched a recruitment drive and hired nine international staff. The main concern for senior staff across the division was a lack of band 6 nurses. This had been resolved after a successful recruitment campaigns in Italy, Spain and Portugal.
- Throughout the division, staffing was assessed on a day-to-day basis and reviewed at bed management meetings. Staff rotas were completed a month in advance to identify any gaps and there were monthly reports on nurse staffing levels.
- Planned nurse to patient ratios for medical wards, both respiratory medicine and cardiology wards across the trust were 1:6 patients in bay areas and 1:4/5 if patients were nursed in side-rooms. We saw specials were utilised across the wards during the day and overnight. Specials are staff that provides one to one support for patients. The nurse to patient ratio for the care of level 2 HDU patients was 1:2 in line with national guidelines.



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- Nursing staff who provided one to one support for patients were referred to as 'specials'. We observed that specials were utilised across the division and especially for patients with dementia or patients at risk of falls.
- Wards across the medical division were almost at establishment (establishment is the term used to describe the numbers of staff and skill mix needed to meet patient needs). On Foulis ward, there were 34 whole time equivalent (WTE) nurses. On Victoria ward, there were 36.64 WTE. Lind ward had 21 WTE nurses. Paul Wood had 34 WTE nurses. On York ward, there were 39 WTE nurses. In the cath labs there were 20.39 WTE nurses. This was all in line with planned establishment numbers.
- The nursing staff throughout the respiratory division was 2% over establishment.
- We observed that where wards used agency staff, staff were inducted onto the ward and were given a buddy that they could go to with questions and queries.
- The turnover rate varied between wards but was assessed from April 2014 to March 2015. Within this time, the turnover rate for the respiratory division was between 2.6% and 19%. The cardiology division had a turnover rate of between 5.3% and 24%.

## Medical staffing

- The proportion of consultants was slightly higher than the England average. Middle career doctors were 4% less than the England average. Registrars were 21% more than the England average and junior doctors were 21% less than the England average.
- There was no foundation level medical staff (F1 and F2) at the Royal Brompton Hospital in Chelsea.
- We observed a medical staff handover at a bed management meeting also attended by ward sisters and nurses. We observed this to be effective, with the consultant giving advice on each patient discussed. NEWS triggers were discussed at the meeting as well as discharge arrangements, staffing levels and resuscitation triggers.
- On the cardiology wards, congenital consultants completed daily ward rounds
- Each subspecialty team had at least two consultant ward rounds on the cardiology wards during the working week. On call subspecialty team consultants visit the wards on Saturdays, Sundays and Bank Holidays.

- Medical staff reported that their workloads were manageable and varied and that there were sufficient doctors on call during both the day and night.

## Major incident awareness and training

- The trust did not have formal major incident training in place. However, all staff were able to recall trust wide simulation days that had taken place.
- Simulation days would take on different scenarios e.g. bomb, snow or fire and would assess the staff's reaction time.
- We observed the major incident awareness forum on the trust intranet and found it to contain key policies and the names and contact details of key trust staff.
- The trust was a member of the Borough Resilience Forum within Royal Borough of Kensington and Chelsea and Hillingdon.
- Fire training was part of the trust mandatory training programme. The trust target for staff having completed this training was 75%. Of the staff within the medicine service 90% had completed the fire training.

## Are medical care services effective?

Outstanding



We rated the effectiveness of medical services as outstanding because:

- The multidisciplinary teams were highly effective and discussed the holistic needs of each patient as well as the clinical requirements of care.
- Care was provided in line with national best practice guidelines and where possible, the medical service contributed to clinical audits e.g. MINAP. The hospital performed very well in the Heart Failure audit.
- The in house pain team who had strong links to the wards managed pain effectively.
- Wards had access to a full range of allied health professionals such as speech and language therapists, dietitians, tissue viability team, physiotherapists, clinical psychologists and a wide range of nurse specialists.
- The majority of allied health professionals were available six days a week and consultants were available seven days per week.

# Medical care

- Nutrition and fluid assessments were regularly assessed and proactive dietitians who were very involved in patient care plans supported patients in meeting nutritional needs. These dietitians had full details of patient's nutritional needs and preferences.
- Practice educators took a hands on role and were based on each ward throughout the division. Staff found their input both helpful and considerate.
- Patients were asked for verbal consent before being treated and we saw evidence of signed consent forms. Staff understood the basic principles of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).
- Staff including healthcare assistants were supported with access to training, clinical supervision and development.
- Use of National Institute of Health and care Excellence (NICE) guidance was in place across the division.

## Evidence-based care and treatment

- The service used national and best practice guidelines to care and treat patients. The medical service used a combination of National Institute of Health and Care Excellence (NICE) and Royal Colleges' guidelines to treat patients.
- Nursing staff informed us that a range of clinical policies and best practice guidelines were available on the trust intranet.
- Patients had their needs assessed at the morning handover, the bed management meeting and the weekly MDT.
- The standards committee met quarterly and had responsibility for cardiology, cardiac surgery, transplant surgery and chest medicine and surgery. New NICE guidelines were presented and NICE quality standards were reviewed, for example, a recent audit has looked at lipid levels and compliance with statin treatment.
- There were frequent local audits that had been completed on the wards; this included, infection control and hand hygiene and equipment check audits.
- The hospital had an audit for compliance with NICE heart failure guidelines, which was audited annually.

## Pain relief

- The trust used a pain assessment tool that ranged from one to ten. The nurses used this tool to assess how well pain relief was working for the patient.

- There was a trust wide pain team available by referral located on Sydney Street.
- On the respiratory wards, there was "intentional rounding" every two hours. This is where staff attends to patients at set intervals to check a range of patient-centred issues. Patients would be asked about pain relief and if they were comfortable.

## Nutrition and hydration

- The 2015 Patient Led Assessments of a Care Environment (PLACE) demonstrated 90% of patients were satisfied with the food and drinks offered by the hospital. This was level with the England average of 90%.
- All patients we spoke with were happy with the standard of the food provided to them. We observed patients being provided with an option as to what to eat. Housekeepers regularly offered patients hot and cold drinks
- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. This tool takes into consideration various factors such as patient weight, BMI and whether any weight has been gained or lost. The tool also has an action plan that documents whether or not the patient was high or low risk. For patients at high risk of malnutrition, a diet of fortified foods and drinks was put in place. The dietitians managed this.
- A dietitian team reviewed patients on the wards on a daily basis. The dietitians were also involved in the multidisciplinary team meetings.
- Speech and language therapists (SALT) were part of the therapies team and were available on request.
- Patients who required assistance with eating their food were provided with a red tray to alert staff.

## Patient outcomes

- The myocardial ischaemia national audit programme (MINAP) is a national clinical audit for the management of heart attacks. MINAP audit results for 2013/14 for the trust were better than the England average for all measures. The Royal Brompton Hospital only enter a small number of patients into the MINAP database because the hospital does not provide an emergency service for the treatment of acute myocardial infarction.

# Medical care

- The standardised risk of readmission on the medical wards was between 19% and 20% this was lower than the England average for both elective and non-elective admissions. Elective admission for cardiology was 17% higher than the England trust.
- The cardiac wards performed well in the Heart Failure Audit 2013/14. This showed that the hospital performed better than the UK average for key markers. For example, of the 202 patients admitted with heart failure in 2013/14, 99% received adequate discharge planning with an England and Wales average of 86%. Overall, the Royal Brompton Hospital performed better than the England & Wales average for all four of the clinical (in hospital) indicators and in five of the nine clinical (discharge) indicators.
- The trust did not take part in the Sentinal Stroke National Audit Programme (SSNAP) or the National Diabetes Inpatient Audit (NaDIA) due to the specialised cardiothoracic nature of the treatment it provides.

## Competent staff

- Practice educators were on hand to provide clinical supervision to both new nurses and nurses who required additional training or assistance. Staff we spoke with throughout the divisions found the practice educators 'excellent' and very well informed.
- Nursing staff were offered the opportunity to rotate across different wards in their division to gain experience in other areas. One nurse told us that she felt 'supported in learning new things'.
- There was a rotational preceptorship in place for junior nurses that saw them being supported by mentors and practice educators. This meant that junior nurses were able to rotate across different specialities, which broadened their experience.
- The cardiology wards had in place, daily learning lectures every weekday. The learning could range from a discussion about complaints from the PALS team or a training session on how to appropriately fill out a MUST form delivered by the dietitian team.
- We reviewed competency records and found that all nursing staff had access to develop further competencies.
- Healthcare assistants (HCA's) had to undertake the care certificate before interacting with patients. The care certificate was knowledge and competency based and

sets out the learning outcomes and standards of behaviours that are expected of staff caring for patients. The HCA's we spoke with stated that they were well supported by the nurses on the ward

- The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation. Several nurses informed us that they felt very supported in approaching their revalidation.
- The hospital provided English classes for newly appointed nurses from abroad.
- Registrars we spoke with told us that it was not always easy to attain training competencies, for example central venous line insertion and chest drainage. A new consultant had recently been appointed to take responsibility for that aspect of medical staff training.
- On Foulis ward, 78% of nursing staff and 70% of HCA's had received an appraisal in the last year (from April 2015 until now). On Lind ward, 90% of nursing staff and 67% of HCA's had received an appraisal in the last year. On Victoria ward, 91% of nursing staff and 67% of HCA's had received an appraisal in the last year. On Paul Wood ward, 68% of nursing staff and 100% of HCA's had received an appraisal in the last year. On York ward, 52% of nursing staff and 50% of HCA's had received an appraisal in the last year.

## Multidisciplinary working

- The medical service boasted a high degree of multidisciplinary team (MDT) working. An MDT is a group of healthcare professionals with expertise in different medical areas who meet, plan, and manage a patient's care plan.
- A broad range of doctors, nurses and allied health professionals attended team meetings and we observed strong collaborative working practices. There were regular cross-site MDT meetings for cardiac patients.
- We observed a cystic fibrosis MDT that was chaired by a consultant. In attendance were three medical registrars, two consultant/specialist nurses, two ward nurses, a physiotherapist, a pharmacist and a manager. Each member of staff had the opportunity to contribute. Ten patients were discussed over the course of the MDT and decisions were made over specific drug therapy and treatment regimes. The holistic and social needs of the patients were also discussed as well as discharge planning.



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- Consultants that we spoke with were proud of the divisions MDT workings and on the collaborative nature of the division.
- One of the physiotherapists we spoke with said that the 'MDT is brilliant; I really feel part of the team'.
- A number of medical staff spoke very highly of the input provided by the clinical psychology team. The psychology team also inputted to the patients transition between services.
- We observed a bed meeting on one of the respiratory wards. This was chaired by a consultant chest physician and attended by 15 medical, nursing and admin staff. The meeting was short and took the form of a brief review of planned discharge dates of patients from the ward, bed availability for admissions and the need for HDU beds.
- The Royal Brompton Hospital had several service level agreements (SLA) with other local NHS trusts. The SLA ranged from neurology and diabetes to general surgery.
- It had a pan London agreement with for stroke services where it had access to clinical advice from a consultant/ Specialist Registrar 24 hours a day, seven days a week.
- There was also a pan London agreement for psychiatry where there was 24/7 single point access telephone support for mental health triage and advice.
- The trust also had cystic fibrosis patients transferred to and from other hospitals.

## Seven-day services

- The majority of the medical services were making positive advancements towards seven-day services.
- There were five cardiology subspecialty rotas which all provided 24/7 consultant cover. Each subspecialty team had an on call consultant who carried out a ward round on Saturdays, Sundays and Bank Holidays to review any new patients and any patients giving cause for concern.
- The wards had access to a full range of allied health professionals six days a week. This included; dietitians, OT's and psychologists.
- Pharmacists visited the wards twice a day with a morning visit on Saturday. There was no pharmacy service available on Sundays throughout the trust however two pharmacists were on call 24 hours a day.
- There was 24/7 access to imaging and physiotherapy services.

- The cath lab team provided elective services on designated longer days and Saturdays to reduce waiting times they also provided an additional on call service for out of hours and weekends emergencies.

## Access to information

- Staff felt as though they had access to the relevant information in order to provide effective care and treat patients in an individualised and timely manner. The number of computers we saw on the wards we visited evidenced this.
- Staff had access to patient and trust information via the computers on the wards.
- Patient's prescriptions were provided via an electronic system that staff could access via a secure login.
- Staff had access to an online learning management system and trust policies and protocols via the trust intranet
- On the cardiology, wards there were a variety of leaflets on information related to cardiac diseases.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was not part of the mandatory training programme but sessions were organised by the learning and development centre.
- We observed patients being asked for their consent prior to the administration of medicines and for other procedure and interventions. The eight medical records we observed, all of which contained signed consent forms for medical procedures, evidenced this.
- We were informed that if a patient had a DoLS in place they were provided with "specials" (staff that provided 1:1 care).
- Across the medical division there was no compulsory dementia testing for the over 70s.

## Are medical care services caring?

Good



We rated the caring aspects of medical services as good, because:

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- Patients received compassionate care by staff and were treated with dignity and respect. We observed staff being friendly and polite towards patients and visitors.
- The Friends and Family Test results scores were high for each of the ward areas. The PLACE score for privacy, dignity and wellbeing was slightly above national average.
- The CQC national audit inpatient survey scores showed high levels of patient satisfaction for dignity and respect and care from staff. These were better when compared to other hospitals.
- Patients we spoke to felt involved in their care and treatment. Patients and relatives thought that they had sufficient opportunities to speak to a member of staff.
- Emotional support was provided by staff directly involved in the patients' care and by specialised staff. The hospital arts programme offered visual and musical presentations to improve patients and visitors' wellbeing.
- The patients we spoke with felt safe in their environment.
- We looked at the results of the patient led assessments of the care environment (PLACE) scores for privacy, dignity and wellbeing. For 2015, the Royal Brompton Hospital scored 86%, compared to a national average of 86%.
- The trust scored 91% in their inpatient survey results for patients being treated with respect and dignity. Both results were better when compared to most other trusts that took part in the survey.

## Understanding and involvement of patients and those close to them

- Patients we spoke with felt involved in their care. They had frequent opportunities to speak with their consultant and other members of the multidisciplinary team. This enabled patients to make informed decisions and be involved in their care.
- Relatives we spoke to were happy with the care their family member received and told us they felt well informed about the treatment plans. They told us there was good communication with the medical and nursing staff and test results were given as soon as they became available. There was sufficient information and regular updates about the treatment progress.
- Relatives we spoke to were happy about the visiting hours on the wards.
- One patient we spoke with said that they saw their consultant every day and 'everything was explained'. Another patient said 'I feel listened to'.
- Visitor accommodation within walking distance of the hospital enabled relatives to stay close to their family member. We spoke to a relative and carer of a patient on Paul Wood ward who stayed in the accommodation and therefore was able to spend more time with the patient.
- We spoke with several nurses who said that 'we are never so busy that we don't have the time to explain things to patients'. The patients had nurses allocated to them each day that they were introduced to and could ask them questions when they wanted.

## Emotional support

### Compassionate care

- We saw throughout the medical wards staff provided care and treatment in a caring and compassionate manner.
- We observed interactions between nursing staff and patients were professional, kind and friendly. Some of the positive comments we received were: "Staff are always willing to help", "Everyone goes the extra mile", and "Everything is golden edged".
- One patient said that the environment was 'relaxed. It's calmer here than at any other hospital I've been to'.
- All patients and the relatives that we spoke with were very positive about the care they or their relative had received.
- The Friends and Family test results showed high levels of satisfaction for each of the medical wards. The response rate was 28%; this was above the England average of 26%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. From March 2015 to February 2016, the medical wards scored between 92% and 100%.
- Patients told us that nursing staff were respectful and protected their privacy and dignity. For example, we observed that curtains were drawn when patients were receiving personal care or interventions.

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- The hospital offered a multi-faith chaplaincy service and provided spiritual support if requested. Staff was aware of how to contact spiritual, pastoral or psychological advisors to meet the needs of patients and their families.
- Patients and relatives told us that they felt staff were approachable and that staff did their best to reduce anxieties or fears.
- A bereavement policy was in place to help staff meet the needs of families at the time of bereavement and to ensure that each family received the care and support required. This service was available Monday to Friday. PALS & Bereavement Service Officers (PBSO's) were responsible to run the service and coordinate the service during working hours (Monday to Friday, 09.00 to 16.00).
- The hospital arts programme, Rb&hArts, offered musical and visual presentations to improve patients and relatives' wellbeing. It presented exhibitions in public spaces and provided live music performances for patients. We observed a harpist playing in patient bays on York ward.
- A 'singing for breathing' group visited Victoria ward every week that assisted patients with their breathing skills as part of their treatment plan.

## Are medical care services responsive?

Good



We rated the responsiveness of the medical service as good because:

- Services were planned and staff were hired to ensure that the needs of local people were taken into consideration and patients were provided with as much choice as possible.
- Wide varieties of specialist nurses were able to provide additional support to patients. In some instances, the specialist nurses worked as a key worker for patients who required additional support with discharge.
- Staff were aware of the patient complaint process and senior staff felt well supported by PALS in dealing with complaints and concerns.
- The new scales on the respiratory wards took patients in the wheelchairs. Disabled patients no longer have to be hoisted up and down in order to be weighed.

However:

- During our inspection the disabled toilet on Foulis ward was being refurbished and therefore disabled patients had to go down in the lift to a different ward that did have a disabled toilet.
- The nature of the building on Fulham Road meant that the wards at the top of the building were extremely hot in the summer. All rooms were provided with fans to lessen the risk against this.
- Some of the rooms on the respiratory wards were quite dark and some of the beds in the bays were close together due to limited capacity.

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

- As an international specialist tertiary service, the trust were aware that their patients could come from all over the world. To accommodate this, leaflets were available in different languages on request. Translation services were available and an interpreter could be booked in advance via a form on the trust intranet.
- There was a nuclear medicine service and an adult congenital heart disease service that provided patients with specialist care required. The trust hired two additional electrophysiology consultants in response to a higher number of referrals and longer waiting lists. Both hospital sites ran additional elective lists on Saturdays to reduce waiting times. During our inspection, a consultant normally based at Harefield Hospital covered one of the electrophysiology cath labs to ensure this list was not cancelled.

## Access and flow

- The service held daily bed management meetings every weekday attended by ward managers, matrons, doctors and consultants. Bed managers and consultants chaired these meetings providing up to date information on bed capacity and responding to division wide bed availability pressures.
- A multidisciplinary team coordinated bed moves. During the period February 2015 to January 2016, 79% (23,437) of patients experienced no ward move, 2% (456) of patients were moved once, 6% (1,867) of patients were moved two times and 14% of patients were moved three times or more.
- From October to December 2015, bed occupancy throughout the medical service saw a decrease

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compared to the same period the previous year. In October, there was a 1.2% decrease from the year before in November a 0.8% increase and in December a 0.8% decrease from the year before. The bed occupancy rate throughout 2016 was on average 88%. This was on par with the England average.

- As part of the lung divisions, quality priorities a target of 90% of cancer patients had to be seen within 20 days. Between October and December 2015 96% of patients had reached the target of 31 day decision to treat to first definitive treatment.
- During the period April 2015 to March 2016, the trust exceeded the England standard of 90% for referral to treatment (RTT) for in thoracic medicine (100%) for patients starting consultant led treatment within 18 weeks of referral. However, the trust performance was below the England standard for cardiology (88%). The hospital informed us that the reason they did not meet the target for cardiology patients was because the treatment required complex electrophysiology procedures under general anaesthetic. To mitigate against this, the service undertook additional evening and weekend sessions to ensure that patients had their cardiology procedures during the extra sessions.
- A catheter lab liaison nurse helped coordinate a smooth patient transfer between wards and catheter labs. This nurse would ensure all patients were ready for their procedure to ensure there were no delays. Doctors in the cath labs told us this had improved the cath lab utilisation.

## Meeting people's individual needs

- Feedback from patients was actively taken into consideration and practice was changed and developed to meet patient's individual needs. For example, on Foulis ward there had previously been only one timing option for when patients could receive i/v therapies. Patients launched an initiative to develop a way their i/v's could be given in a timelier manner. The ward has since developed a three-time option for patients that operates all day. Patients we spoke with told us that these additional options had improved waiting times for i/v therapies and enhanced patient experience. Patient were now able to receive medication at a time that suited them.
- On the cardiology wards there were over 40 pamphlets or publications available to patients which could all be requested in another language if need be.

- There was a positive patient ID group made up of nurses who ensured that staff were asking the patients name and date of birth prior to administering medication.
- Patients could access a wide variety of clinical nurse specialists including nurses who specialise in diabetes, stroke and palliative care as well as a nuclear medicine team to assist with various co-morbidities.
- A multi-faith chaplaincy team could be contacted.
- There was a quiet room located on Victoria ward.
- Throughout the inspection, we observed physiotherapists, dietitians and psychologists were actively involved in patient care.
- If a patient suffered from dementia, their doctor and the safeguarding lead would ensure care was appropriate and their individual needs were taken into consideration when developing their care plan. The patient was provided with the same nurse so that there was a degree of familiarity and be provided with 1:1 care.
- There was a trust wide learning disabilities specialist nurse. This role was to ensure that patients with learning disabilities were comprehensively assessed.
- As part of the trust 'patient administration system' patients who were severely blind or deaf were flagged up and had a complex needs assessment performed.
- Most wards had a waiting room with a television and access to pamphlets.

## Learning from complaints and concerns

- The hospital had a target to respond to formal complaints within five weeks of receipt. Data provided by the trust showed there had been 29 complaints raised across the medical division from April 2015 to March 2016. All but two complaints were responded to within five weeks.
- On the respiratory wards, the matron dealt with both informal and formal complaints. Across the division, staff felt comfortable approaching PALS if they felt unable to handle the complaint.
- Staff encouraged patients to address their concerns with them directly so that they can reach a balanced conclusion as soon as possible.
- Learning from complaints was discussed at the monthly ward meetings across the division.
- On the respiratory wards, the sisters met on a Monday morning to discuss incidents, complaints and concerns from the previous week.

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- Comment cards were available on each ward that could be filled out if patients had concerns they did not want to speak with staff about. The trust had a policy on Managing Patient Complaints that was due to be reviewed in 2018.

## Are medical care services well-led?

Outstanding



We rated the medical services to be outstanding for well led because:

- The vision and strategy of the service aligned directly into the trust vision and was embedded amongst staff throughout the service.
- Medical care services were well led and we observed high levels of integration and corroboration within teams. For example, both the respiratory and cardiology division worked well with an in house nuclear medicine team.
- Senior management and divisional managers were visible on wards and there were patient facing dashboards, which showed ward results at the entrance to each ward.
- There was an effective system of clinical governance and risk registers were up to date and proactively managed. Learning from risk issues was disseminated to staff and staff understood their role within the hospital.
- Medical services were especially good at taking on the opinions of the public and engaging with the patients that they treated.
- Staff were actively involved in contributing to positive changes and was engaged with the development of the division.
- There were impressive and cutting-edge innovations taking place throughout the division.

### Vision and strategy for this service

- The trust's vision was summarised 'to be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world'. The mission underpinning this was; improving patient safety and satisfaction, providing world-class specialist treatments, bringing innovation to clinical practice, attracting world class clinical leaders and investing in services and technologies.

- The values of the trust were to care, to respect and to be inclusive. Staff were aware of these values and incorporated these values into their work.
- Within the medical division, both the respiratory wards and cardiology wards had their own vision, which aligned directly into the trust vision, to provide outstanding care to patients. Both junior and senior nurses knew the service vision and embedded it into clinical practice.

### Governance, risk management and quality measurement

- The trust risk register was maintained up to date and reviewed regularly. The majority of risks related to the nature of the building. Staff were aware that the building was old and no longer fit for purpose.
- Senior staff knew there was a risk register and ward managers and matrons were able to tell us what the key risks for their clinical area were. These directly corresponded to the risks we identified during inspection.
- Quality and safety group meetings took place formally every six weeks for the heart division. We observed minutes of the last meeting and found the discussion points to include action point for safety thermometer results, infection control and the quality of the auditing programme. Also discussed was the management of deteriorating patients, pressure ulcers and medicines management.
- Since April, the nurses re-started the nursing quality groups. These were led by band 6 nurses and focus on five key patient areas e.g. Communication, the admission process, the discharge process, fundamentals of nursing care and patient safety. The objective of the groups was to make a difference and 'enhance the patient experience'.

### Leadership of service

- A clinical governance lead, consultants and a lead nurse led the division. There was a matron of the heart division and one for the respiratory division.
- Staff were able to name key members of the executive board and reported that there was visibility of members of the trust board. Staff across the medical division had good interaction with their divisional managers who were described as 'hands on' and 'approachable'.



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- Junior and senior nurses told us that matrons and senior staff were highly visible on wards. We saw that senior managers knew the staff and communication levels were good.
- There was executive patient safety walkabouts every quarter where members of the executive team engage with both staff and patients.
- We observed high levels of integrated services led by the heads of services throughout the division. Heads of services informed us that they felt very supported by the executive team to manage and improve their services.

## Culture within the service

- Staff felt 'supported' by their leaders and several staff members compared working at the Royal Brompton Hospital to being like 'a family'. Staff discussed their job roles and their division with a high degree of passion.
- There was a high degree of collaboration across the service. This was evident in our talks with consultants, ward managers and divisional managers who all spoke highly of the multidisciplinary workings in each division.
- Staff were aware of how to report incidents and felt comfortable doing so via the trust online incident reporting system.
- There were various opportunities for further learning within the cardiology department. Lunchtime sessions took place every weekday on a range of topics and staff informed us that they found these sessions very helpful and practical.
- The nurses in the cardiology wards told us that they had a good working relationship with consultants who they called 'approachable'.
- Nurses and doctors told us that there were vast opportunities for further education. There were time protected study days and opportunities to develop both professionally and personally.

## Public engagement

- We observed good opportunities for public engagement throughout the respiratory division. The staff actively took time out to listen to the views and opinions of the patients. An example of this was a recent group of patients who came up with an idea to avoid being disturbed for hot drinks. The patients rooms now have a hot drinks sign outside their door that they can use to avoid being disturbed unnecessarily.
- As some of the conditions dealt with at the trust were lifelong conditions, there were measures put in place to

ensure that patients remained well connected. An example of this was the outreach teams throughout the respiratory division who assisted cystic fibrosis patients in the community. Patients are provided with lessons whilst at the trust including subcutimmunoglobulin therapy and how to use pumps at home.

- Patients could use an online cystic fibrosis web page to speak with consultants and each other.

## Staff engagement

- There were consultant led 'grand rounds' every week that were open for all staff to attend. The nurses we spoke with stated that 'they are helpful but we don't get to go during work time'.
- There were monthly ward meetings where new policies, new staff, changes in practice, audits and infection control were all discussed. The aim of the meetings was to see what areas could be improved.
- There were regular newsletters from the CEO that explained the corporate happenings of the hospital and the budget.
- The trust holds a bi-annual champions award where different care groups or members of staff could be nominated for excellence in their work and be awarded £1,000. We spoke with a team of nurses who have once been afforded the award. They were very proud of the win and even more so of the nomination itself.
- Non-patient facing staff e.g. HR, IT often get involved in patient facing tasks. The HR team go onto the wards and assist with the FFT process. They get to speak with patients about their care and staff members about ward improvements. This offers a way for all staff to get involved in the process.
- Trust wide monthly Schwartz rounds enabled hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim was to offer staff a safe environment in which to share their stories and offer support to one another.







## Innovation, improvement and sustainability

- The medical division boasted a vast array of innovative schemes and plans.
- In the last 18 months, the trust launched a one-stop breathlessness service. The service aims to provide a one-stop assessment to find out the cause of unexplained breathlessness.

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- The site developed a service in order to enable patients with implantable devices to use MRI machines. This involved producing a robust and safe process to enable patients who would otherwise be declined an MRI. In order to do this, the quality and risk team had to be heavily involved in the production.
- There were plans in place to re-develop which would include upgrading to three new scanners on site.
- The cardiac oncology service works in collaboration with another trust to see patients quicker. As chemotherapy affects left ventricle function, the objective of the service was to ensure that clinic, assessment and MRI are all done on the same day for patients living with heart problems caused by their cancer treatments. The cardio-oncology clinic at the Royal Brompton Hospital was the only dedicated cardio-oncology clinic in the UK. The service also carried out a study that suggested a link between cancer and a decline in heart function.
- The clinical genetics and genomics laboratory was a joint venture between Royal Brompton & Harefield NHS Trust and the National Heart and Lung Institute at Imperial College London. The service was based at the Royal Brompton Hospital and was in the final stages of UKAS medical laboratory accreditation (ISO15189) and the vision of the service was to offer diagnostic testing for families and individuals at risk of inherited disease. A team also led a study with a top university that interpreted the significance of gene mutations in cardiomyopathy patients.
- One of the cath labs was equipped with a stereotaxis magnetic navigation system. The consultant we spoke to explained that this allowed remote control of the catheter and thereby reduced radiation exposure for staff and patient. We were told that the system reduced the risk of complications and procedure time for example in patients with congenital heart disease.
- Experts from the service partnered with Penn Cardiovascular Institute to lead an international study into whether peripartum cardiomyopathy (PPCM) can have a genetic cause.
- The service used a cutting edge technique for patients with chronic obstructive pulmonary disease (COPD). The procedure used electrodes to destroy branches of the vagus nerve in lungs. This treatment was in partnership with another London hospital.
- At the time of our inspection there was a clinical trial taking place aimed to improve treatment for patients with atrial fibrillation by removing some of the heart's nerve endings. This technique was done by targeting nerve endings for catheter ablation treatment.

# Surgery

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

## Information about the service

The Royal Brompton Hospital provides specialist cardiac and thoracic surgery services for both the local population and for those further afield who require specialist treatment not available elsewhere.

Between September 2014 to August 2015, there were 4906 referrals to surgical services at the trust. Between May 2015 and April 2016 the Royal Brompton Hospital (RBH) performed 2952 operations; of these 57% were cardiac operations and 43% were thoracic operations, 89% of these were elective procedures and 11% were emergencies. The surgical services were managed within the heart and lung divisions.

The hospital had 360 general and acute beds. Surgical services were delivered from a theatre suite, made up of six theatres and an additional hybrid theatre for interventional surgical procedures. Surgical patients were cared for on both Princess Alexandra ward and Sir Reginald Wilson Ward which were located on the fifth floor of the hospital. Princess Alexandra ward had 35 beds in total, of which five were single side rooms. Sir Reginald Wilson Ward had 28 single bedded rooms for private patients.

The cardiac and thoracic surgery specialist services formed part of the wider heart and lung divisions. Each division was further split into care groups which focussed on specific diseases.

We visited the surgery services on Tuesday 14, Wednesday 15 and Friday 17 June 2016. We followed the patient journey, from admission through to the operating theatres

and then through immediate post-operative recovery. They continued through the surgical wards and were finally discharged. We looked at the services provided for both inpatient and elective day case patients.

We visited the surgical pre-assessment area, the surgical wards and main operating theatres. We spoke with over 50 members of staff including managers, doctors, nurses, allied health professionals, health care assistants, support staff and administrative staff. We spoke with 10 patients and their family members. We observed their care and treatment and looked at 10 care records. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.



# Surgery

## Summary of findings

We rated the surgery service at The Royal Brompton Hospital as 'Requires Improvement'. This was because:

- Staff we spoke with were unaware of the systems, processes and standard operating procedures to ensure cleanliness and safety of equipment and the environment in theatres.
- Staff caring for children and young people in the recovery area were not trained to the required safeguarding training standards.
- Risks to people who used the services were not always assessed, monitored and managed. The World Health Organisation (WHO) five steps to safer surgery checklist was not fully embedded. National Early Warning Score (NEWS) charts were not always used appropriately to guide escalation.
- The on-call staffing rota in theatres meant staff were working excessively long hours without the required rest periods.
- Staff satisfaction was mixed. There were a number of staff who told us they felt bullied in their work place. Staff told us they did not always feel actively engaged in changes or empowered to speak up.
- Management structures in theatres were not yet working cohesively with different staff groups managed by different managers and staff told us there was little engagement with them to manage change.

However

- The trust had good processes for the reporting of and escalation of incidents.
- Staff were committed to learning from incidents. When incidents occurred, patients received a sincere and timely apology. We saw examples of actions in place to improve processes to prevent the same happening again.
- Staffing needs were based on the acuity of patients. There were adequate number of nurses in the surgical wards. Theatre vacancies were managed, using bank and agency staff.

- There was a good understanding of the duty of candour requirements. Staff were able to give us examples where they had implemented these, alongside support from senior staff.
- There were high completion rates of mandatory training across the services.
- We saw that care and treatment was coordinated with other services and other providers. There were innovative approaches to providing integrated person-centred pathways of care, particularly for people with multiple complex health needs.
- There were good patient outcomes across the surgery services in both the heart and lung divisions.
- Feedback from patients who used the service and those close to them was consistently positive. People thought that staff went the extra mile and the care they received exceeded their expectations.

# Surgery

## Are surgery services safe?

Requires improvement



We rated the surgical services at The Royal Brompton Hospital as 'requires improvement' for safe. This was because:

- The World Health Organization (WHO) Surgical Safety Checklist was only partially embedded at the time of inspection. Although there had been recent improvements in its' use, parts of the checklist were not routinely used and observations demonstrated staff were not fully engaged.
- There were not always systems in place to ensure the cleanliness of the environment and the equipment in the theatre department or at night on the ward. We saw trailing wires on the floors in theatres, causing trip hazards and patients on the wards told us the toilets were dirty at night.
- Staff in the recovery area caring for children were not trained in level three safeguarding. The Royal College of Paediatrics and Child Health specifies that this is the level of training appropriate for their role.
- National Early Warning Scores (NEWS) had been incorrectly calculated in half of the record charts we reviewed. NEWS determines the degree of illness of a patient and prompts intervention.
- Staff in theatres told us they worked excessively long hours due to the on-call system. Rotas we looked at demonstrated staff working seven days in a row, for long hours without required rest periods. At the time of the inspection, senior staff had recognised this as an issue but no revisions had yet been made.

However:

- The trust had good processes for the reporting of and escalation of incidents. There were systems to share learning points from these incidents.
- All of the clinical areas we visited were visibly clean. Compliance with hand hygiene processes had improved.

- Staffing needs were based on the acuity of patients. There were adequate number of nurses in the surgical wards. Theatre vacancies were managed appropriately, using bank and agency staff.
- There was a good understanding of the duty of candour requirements. Staff were able to give us examples where they had implemented these, alongside support from senior staff.
- There were high completion rates of mandatory training across the services.

## Incidents

- There were no never events within the surgery services in the period March 2015 to April 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The occurrence of a never event could indicate unsafe practice.
- Over the previous six months there had been a 34% increase in incident reporting within the heart and lung divisional services. Data provided demonstrated an upward trend in the number of incidents reported between March 2015 to April 2016. There were 1001 incidents reported within the heart division at RBH and 569 incidents reported within the lung division between April 2015 and March 2016.
- There had been seven serious incidents (SIs) within the heart division at RBH and two SIs reported within the lung division. We looked two serious incident reports. These included a detailed chronology of events and a thorough investigation, including a root cause analysis (RCA) of the incident. They also included discussion of duty of candour requirements, recommendations for immediate and future actions. The reports specified arrangements for sharing these recommendations, learning and actions, both locally and across the trust.
- We saw that when Serious Incidents were investigated and reviewed an action plan was devised.
- Monthly data demonstrated the theatres, Princess Alexandra ward and Reginald Wilson ward were all within the top 10 locations in the hospital for reporting patient safety incidents in March 2016.

# Surgery

- All investigated patient safety incidents (PSIs) are reported to the National Reporting and Learning System (NRLS). Information received in April 2016 demonstrated that 50% of all PSIs were reported more than 27 days after the incident had occurred. This was slower compared with other similar acute hospitals.
- Trust policy required all incidents to be reviewed within 10 working days. There were 48 incidents within the heart division where this review period had passed. However, Reginald Wilson ward was one of the top five locations for investigating incidents within the 10 day timeframe.
- Medication errors accounted for the highest number of incidents reported. These errors included medications given but not recorded, incorrect infusion rates and late administration. The improvement of medication management was a priority within the heart division. Nurses told us there had already been improvements made to the way medicine rounds were conducted to ensure concentration on the task.
- Staff across the surgical services, both on the wards and in theatres, were able to tell us how to report incidents. Staff were able to give examples of incidents they had reported. Staff told us there was a good reporting culture, in which they were encouraged to report 'near miss' situations, as well as incidents that had occurred. Staff were offered training in how to correctly complete incident forms.
- The clinical director for theatres gave a lecture to all members of staff about 'never events' including the definition, incidents deemed to be never events and their implications for the trust, both financial and in terms of governance and reporting. This lecture was mandatory for all staff.
- Staff told us about two never events which had occurred outside of the reporting period but had resulted in improvements. The two never events both related to items retained post-surgery. For example, there had been a disagreement over the number of swab packs used during one of the operations, which led to a retained swab. Staff were able to tell us about a quality improvement programme following this which involved education, such as cross-site mandatory lectures and

discussions to encourage openness. An action plan and flow chart was put in place. All staff were now involved in the surgical checklist to confirm all surgical items had been accounted for.

- Information about incidents and learning points were shared at morning briefings and handovers, through email, during ward meetings and the monthly governance meetings. We also saw information boards which detailed recent improvements in care due to reported incidents.
- Nurses on the wards were supported by their matrons and ward managers when incidents occurred. One nurse on Princess Alexandra ward described the support she received when a medication incident occurred during a night shift.

## Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All staff we spoke with had good awareness of duty of candour requirements. Staff explained that patients should be informed if an incident occurred, given an apology and told that an investigation would take place. Staff were able to give examples of incidents where the duty of candour requirements had been applied.
- We looked at quality and safety meeting minutes from the lung division which demonstrated the use of duty of candour requirements when SIs occurred within the division.

## 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, falls with harm to patients and venous thromboembolism (VTE) incidences.

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- Safety thermometer results from March – May 2016 were displayed at the entrances to ward areas. On Princess Alexandra ward, there had been three falls and one pressure ulcer. On Reginald Wilson ward, there had been four falls and two pressure ulcers.
- There were no incidents of venous thromboembolism (VTE) reported from March – May 2016. All patients were assessed on admission to the unit for risk of VTE by the admitting doctor. These assessments were reviewed within 24 hours of admission and then every seven days, or more often if their condition changed
- Band 6 nursing staff told us they were given a management day in which to input data and complete these safety thermometers.
- We spoke with the tissue viability nurse who had started ward rounds with the matron and ward managers to assess patients' skin integrity in order to reduce the number of pressure ulcers.
- Patients wore yellow wristbands. This was a new initiative being trialled to alert staff to those patients at high risk of falls.
- Two patients we spoke with on Princess Alexandra ward told us they felt the cleanliness of the ward at night was not as good as it is during the day. They reported that the toilets were often dirty at night.
- The 2015 Inpatient Survey demonstrated the hospital scored slightly lower than the national average for cleanliness.
- Hand hygiene audits took place weekly and were carried out by the infection control link nurse within each area. Information received prior to inspection demonstrated that improvements in hand hygiene and BBE were required. For example, on Princess Alexandra ward, the rate of hand hygiene compliance was 79% and BBE compliance was 85%. In the recovery area of theatres, the rate of hand hygiene compliance was 89% and BBE compliance was 97%. During inspection, we noted that results had improved in both the recovery and the ward areas, demonstrating compliance rates of above 95%.
- There had been no cases of meticillin-resistant staphylococcus aureus (MRSA) for the 12 months prior to inspection. Data provided demonstrated there had been no cases of hospital acquired clostridium difficile between March 2014 to April 2015.
- In 2015, an increase in the rate of surgical site infections (SSIs) was reported, bringing the hospital above the national average. In August 2015, there were 31 SSIs after coronary artery bypass grafts (CABGs). This worked out to a rate of 6.5%, above both the trust target of 2% and a national benchmark of 1.2%. In June 2015, there were 45 SSIs after cardiac surgery, at a rate of 4.4%. Similar trends were noted amongst paediatric surgical patients with SSI rates above that of the national average.
- Action plans were implemented, which included root cause analysis to identify specific areas of improvement. Action plans included: improvements to surgical site dressings, the use of surgical bras for women, and the photographing of all surgical sites prior to patient discharge. Snap shot audits were carried out which demonstrated 87% of patients had the correct dressing in situ and 60% of female patients were wearing a bra post-operatively.

## Cleanliness, infection control and hygiene

- Clinical areas we visited were visibly clean, well-organised and clutter-free. We observed staff washing their hands and using hand gel between seeing patients. Most staff complied with the 'bare below the elbows' (BBE) policy but we observed two consultant members of staff in clinical areas wearing wristwatches, unchallenged.
- We saw no evidence of a system to ensure the cleanliness of theatre equipment within the theatre department. Staff told us they used antibacterial wipes to clean equipment at the start and end of each day, as well as in between patients. One theatre nurse told us they use 'I am clean' stickers and a book to log the cleaning of equipment, but neither could be produced on request. Items of equipment were not labelled as clean at the time of inspection.
- We observed the use of dated and signed 'I am clean' stickers on equipment across the surgical ward areas.

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- Current SSI data from January 2016 demonstrated the SSI rate for CABG patients was 1.9% and 0% for cardiac patients.
- Coronary artery bypass graft (CABG) patients were assessed prior to surgery using the Brompton Harefield Infection Score (BHIS). This was a tool used for predicting the risk of surgical site infection.
- Staff on Reginald Wilson Ward used a cohort nursing style to nurse several patients with the same infection. They wore scrub uniforms, which the hospital provided daily. Each healthcare assistant who was caring for a patient one on one was told they must not attend to any other call bells.
- The patient board on the ward included a sticker to alert staff to those patients who had infections so that correct infection control precautions could be taken by all staff.

## Environment and equipment

- We checked a range of equipment, both in theatres and in ward areas. All equipment we checked was safety tested according to regulation. All items were clean and stored appropriately.
- We saw both adult and paediatric difficult airway equipment trollies available in theatres. Staff completed daily checklists with no omissions. Equipment we sampled from these trollies was clean, stored in the correct place and within date.
- Resuscitation equipment was available in all clinical areas. Security tabs were present and intact on each. Prior to inspection, several incidents had been reported due to resuscitation equipment not being checked on a daily basis. However, during the course of the inspection, we saw that checklists had been completed daily with no omissions.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available. They were stored in an organised, efficient manner in the anaesthetic and recovery rooms.
- In the theatres we saw loose wires on the floor, which created trip hazards. These were not identified with tape or covered over in order to prevent trips or falls. The presence of cables was a known risk and had been added to the risk register. However, there were other parts of the trust which had mitigated this risk.

- The availability of equipment was discussed during team briefs at the start of each theatre list. However, during inspection we observed the unavailability of a transoesophageal echocardiogram probe during a procedure. This had not been highlighted during the team brief.
- Each ward bay had a daily checklist to ensure safety equipment was checked. Each bed had an airway bag above it with basic equipment to use in case of emergency.

## Medicines

- Treatment rooms were clean and tidy in all areas we visited. Cupboards were locked and clearly labelled with details of their contents.
- Staff recorded room and fridge temperatures on a daily basis. Within theatres, all temperatures were found to be within the recommended range. However, on Princess Alexandra ward, there were inconsistencies in the daily recording of medicine fridge temperatures. Staff had not completed the temperature chart on six of the previous 14 days.
- Staff had access to British National Formulary (BNF), as well as up-to-date policies and information relating to medicines management (including the antimicrobial formulary) via the trust intranet. We also saw guidance to encourage patients to take more responsibility for their own medicine administration.
- In theatres, medication was drawn up in labelled syringes for each patient. In one empty anaesthetic room, medication which had been drawn up was left out on the side. Staff told us these were locked away at the end of each shift. Medications were also kept in trollies within theatres to ensure easy access during an operation. These trollies had key padlocks and were locked at the end of each shift.
- The hospital used an electronic prescription and medication administration chart. Doctors reported that only one user could access a patient's electronic prescription chart at any one time, which caused delays in prescribing. This was due to the initial user having to be identified to log off in order to grant access to a new user. The trust told us the system ensures that only one

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person can update a patient's prescription chart at a time. They told us this was an important safety feature as it prevented two prescribers prescribing simultaneously for the same patient.

- We looked at three electronic prescription charts and found no delayed or omitted doses of medication. One nurse told us there were some issues with the electronic system as it could appear that doses of medicines had been delayed or omitted (marked in red), even though those doses had physically been given. The pharmacy manager confirmed that the system did not always update the administration timings in real time. There was therefore a risk that patients could receive double doses of medication. This risk was not identified on the hospital's risk register.
- Controlled Drugs (CDs) were audited on a daily basis. Appropriate storage arrangements and documentation relating to CDs were in place and complete. On Princess Alexandra ward, we observed staff double-checking and signing for the administration of controlled drugs in line with the trust policy.
- A medicine safety thermometer dashboard had been developed. The dashboard displayed the percentage of patients with their allergy status documented, along with the number of patients with an omission of any critical medicine and the proportion of reconciliation started within 24 hours of admission.
- The pharmacy teams had begun daily microbiology ward rounds to consider those patients on antibiotics. This was to reduce unnecessary antibiotic use and was led by a consultant microbiologist.

## Records

- We looked at 14 medical and nursing records across theatres and ward areas. The hospital used mainly a paper-based record system for recording care, treatment and surgical interventions. Nursing and medical records were accurate, fit for purpose and completed to a good standard for the most part. They were securely stored behind nursing stations in each clinical area.
- Electronic patient record systems were also in use in some areas of the hospital to record patient information. Projects were underway to improve

information storage to prevent duplication. Ward nurses told us that all relevant information was kept within the paper notes. However, this meant that details on the electronic flagging system could be missed.

- Although records on the wards were generally complete, several were missing staff signatures and were not dated. In addition, nursing staff in theatres completed pre-operative safety checklists but some of the signatures were missing. Anaesthetists and perfusionists used an electronic critical care and anaesthetic information system in theatres and recovery areas to record patient and treatment information.
- Medical and nursing pre-operative and post-operative integrated pathways were used to record patient care. These were updated regularly to ensure all information was kept in one place. These consisted of a patient's medical history, their pre-assessment information, any risk assessments, their admission information, the theatre checklist, physical observations, handover details, and discharge planning information.
- Care records were standardised for post-operative care. Nurses told us this was helpful in coordinating patient care and prompting interventions such as dressing changes.
- Prepopulated consent forms were in use for most procedures. We looked at four surgical consent forms. All consent forms were legible and complete. Staff were reminded to offer patients a copy.

## Safeguarding

- The trust had a policy in place to safeguard vulnerable adults and children. This was readily available and staff were able to locate this on the intranet.
- Staff in the recovery area, who cared for both children and adult patients, told us they were unsure of the level of safeguarding training they had received. They told us there had been no face-to-face training. Training information provided by the trust demonstrated 61% of staff had received Safeguarding Children level two training. However, national guidelines state all staff working with children should be trained up to level three which would include a face-to-face training



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session. The trust has since recognised this issue and has identified those who require the level 3 training, with a program to achieve this for all staff before March 2017.

- Staff in theatres were clear about their role in safeguarding patients. Staff told us the importance of checking the correct consent form had been signed and discussed, ensuring the patient's understanding of the procedure. Staff were able to discuss safeguarding triggers and different types of abuse. They were familiar with the process to follow if they had any concerns about patients in their care.
- In ward areas, staff were similarly confident in the processes to follow if they suspected safeguarding concerns. Ward staff were able to tell us how they would report a safeguarding concern and one nurse told us about a recent safeguarding alert they had raised. Staff were able to name the safeguarding lead for the hospital.

## Mandatory training

- The trust target for mandatory training compliance was 75%. In March 2016, staff working within the surgical services were up-to-date with all their mandatory training, with the exception of safeguarding children level two and medical gas training. All other mandatory training topics demonstrated completion rates of 100%.
- Staff we spoke with confirmed they had received a range of mandatory training and adequate time to attend teaching sessions. In theatres, monthly clinical governance days were used to ensure staff could access further training within the department.

## Assessing and responding to patient risk

- All patients attended a pre-assessment visit prior to their operation date. During this appointment, nurses discussed on-going risk factors and referred patients into services to reduce these. This included dietitians for patients who had a high body mass index (BMI), smoking cessation services and diabetic specialist services.
- All surgical procedures were consultant-led. Patients were reviewed either by a consultant surgeon or consultant anaesthetist irrespective of pre-operative mortality risk.

- Patients were also assessed at pre-assessment appointments using the Brompton Harefield Infection Score (BHIS). Patients that scored highly (four or above) would follow a protocol prior to their surgery to reduce the risk of infection. This included a full body wash, a mouth wash and a course of antibiotics.
- Patients' clinical observations were recorded and monitored in line with the NICE guidance, 'Acutely Ill-Patients in Hospital.' A scoring system known as a National Early Warning Scores (NEWS) was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating. We saw staff on the surgical wards and in recovery areas recording patient observations such as heart rate, respiratory rate, blood pressure, temperature and pain scores. On the wards we observed incorrect scores on four out of eight charts we reviewed. A NEWS audit completed at RBH during March 2016 identified greater compliance than that found during inspection. Correct documentation/compliance ranged between 84% - 96%. The audit demonstrated all (100%) charts had a news score recorded. Of these, 86% were correct.
- Escalation procedure were in place for deteriorating patients. Day time deteriorating patients were escalated to the ward based medical teams (ACHD) and nurse practitioners (EP, Intervention, cardiac surgery, thoracic surgery) and where appropriate, referred to the Consultant on duty in the HDU. In addition to this there was a 3 pm NEWS board /safety huddle round conducted on each surgical ward led by the matron of HDU. At night a deteriorating patient was escalated by the ward nurse in charge to the night practitioner team, who reviewed patients and discussed with the relevant on shift SpR clinical team.
- Appropriate assessment tools were used to document various potential risks to patients. We saw completed examples of assessments such as the waterlow pressure ulcer risk assessment, the malnutrition universal screening tool (MUST), the bedrails screening tool, the venous thromboembolism tool (VTE) and Safer Skin Care (SSKIN) assessment. This information was utilised to manage and promote safe patient care.
- Wristbands were used to identify any patient who had been assessed as a high fall risk. This information was discussed during handover as it helped staff to identify patients around the ward who may be at risk.

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- In theatres, we saw the World Health Organisation (WHO) safer surgery checklist tool in use. However, we observed four of the five steps were being used. At the end of an operation, we observed that it was unclear who was leading the sign out process and staff seemed distracted and less engaged with this part of the process.
- Consultant anaesthetists told us the fifth step of the WHO checklist (de-brief) was rarely used. Audit data did not include a de brief step. Information provided by the trust demonstrated plans in place to implement the fifth step of the checklist.
- Weekly WHO documentation audits assessed compliance with the WHO safety checklist. However, there was no evidence that observational audits were completed to assess staff engagement. In April 2016, 78% of checklists were completed. Staff recognised that there were improvements which could be made. For example, recent changes ensured that the first patient on the theatre list would not be prepared and brought down to theatres until the team briefing was completed with the consultant surgeon present.
- Interventional radiology services were located within the hospital. They were available seven days a week if required for out-of-hours emergencies.
- There were blood fridges within the theatre complex. Support staff ensured patients' blood was readily available in the theatre fridge prior to an operation to avoid access delays.
- Band 5 nursing staff reported good out-of-hours cover from the medical and surgical staff, along with additional support from nurse practitioners. They all knew how to access the junior doctors and the registrar. Nurses felt confident in calling the consultant out-of-hours. They all used the SBAR (situation, background, assessment and recommendation) tool for hand-over to doctors to ensure consistency of information.
- The trust provided information which demonstrated the delivery of the sepsis six bundle was included in their safety improvement plan 2015-18 and NEWS observation charts had been redeveloped to include

relevant elements. However, Band five nurses did not yet have an understanding of the 'Sepsis Six' pathway. Practice educators confirmed that this was not taught as part of any training given to nurses by the trust.

## Nursing staffing

- Staffing levels across the surgical services were sufficient to deliver safe patient care. Vacancies in theatres were managed with regular bank or agency staff. Staff told us there were enough staff to provide safe patient care. The nurse staffing report for February 2016 showed all surgical wards were regularly overstaffed with trained nurses, due to levels of patient acuity.
- Nurse staffing numbers were displayed at the entrance to each ward area. During our inspection, we observed that planned numbers matched the number of staff on shift.
- The number of nurses required was assessed using the safe nursing care tool audit. This was carried out twice a year, in January and June. Staff informed us that staffing numbers had recently been increased due to the complexity of patients and patient demand in the pre-assessment team. On Reginald Wilson ward, they used this tool up to four times a year to assess their need for staff.
- A recent overseas recruitment drive had taken place to improve staffing numbers. Staff from overseas who required support with their English were booked onto language classes facilitated by the hospital.
- There were currently 12 nursing vacancies within theatres. These were covered by bank and agency staff. Between January and March 2016, 14 – 16% of shifts were filled by bank and agency staff. Both the matron and senior nursing staff told us that theatre agency usage was block-booked to ensure staff were proficient and competent in their skills.
- Theatre induction packs for bank and agency staff had been updated in April 2016. Packs included an orientation checklist and information on key policies. On the ward, agency staff had to complete an induction checklist. There were also information files, which agency staff had to read before commencing their shift.
- Weekly on-call staffing rotas were in place in theatres. These identified individuals to contact for out-of-hours



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emergency work. Staff in theatres voiced concerns over these on-call rotas as these were in addition to standard 37.5 hour working weeks. Staff demonstrated that weekend on-call work could sometimes require them to work seven days in a row for long hours. Staff could sometimes work over 60 hours in a seven day period due to on-call requirements.

- Managers and senior nurses described how when staff were on-call at night and worked beyond 2am they would not have to come in the next morning. However if staff finished before 2am they could be working the next morning (starting at 7:30am) without the required rest period.

## Surgical staffing

- Health and Social Care Information Centres (HSCIC) statistical data from September 2004 to September 2014 showed that the average proportion of consultants was 38%, compared to the England average of 41%. Middle career doctors made up just 1% of doctors, compared to the England average of 11%. The registrar group averaged 60% during this period, compared to an England average of 37%. Junior doctors at the trust made up just 1% of doctors, compared to an England average of 12%.
- Staff on the wards felt supported by the doctors and told us there was always senior medical support when needed.
- Patient care on the surgical wards was led by individual teams supported by junior medical staff to assess and treat patients 24/7. Weekday cover on the wards was provided by the various teams of doctors from each of the disease groups.
- Junior medical staff were supported by a consultant on-call for urgent and emergency care at night and at weekends. Consultants were present in the hospital from 7.30am – 6:00pm on weekdays.
- Daily ward rounds took place. These ward rounds were not consultant-led and were mainly carried out by the registrars.
- Medical staff reported that recruitment into junior medical staff posts was difficult. Locums were often used. We spoke to locum staff on the unit who said their induction had been thorough and involved time with the consultants of each unit.

- Reginald Wilson ward had a resident medical officer (RMO). The RMOs we spoke to felt the staffing was adequate. A locum RMO we spoke to said their induction had been of a good standard.

## Major incident awareness and training

- Senior nursing staff we spoke to on the wards seemed unclear about the role of their ward during a major incident. They knew that they could locate the trust's 'Major Incident and Emergency Response Plan' (version five issued November 2014) on the intranet. However, no hard copies were available on the wards for reference in the event of an IT system failure. The Theatre Manager had a hard copy of the major incident plan but did not have a role specific plan for theatres.
- The on-call executive and the on-call manager carried the major incident and emergency response plan at all times. The on-call senior manager made decisions to suspend critical services and to halt the acceptance of emergencies if appropriate. All planned elective surgery would be reviewed in the event of a major incident.
- Senior nursing staff we spoke to had not received any formal major incident training from the trust.
- Action cards for wards and departments were produced by the trust in the event of a major incident. The senior staff we spoke to made no reference to these action cards and they were not evident during the inspection.
- In the event of a major incident, there was an agreement of mutual aid with Chelsea and Westminster NHS Trust, but no specific memorandum of understanding.
- The trust had an Emergency Planning Officer and Business Continuity Manager.
- The trust had identified separate Incident Control Centres for both Sydney wing and Fulham wing. These were included in the major incident plan.
- The major incident and emergency response plan was due for review in August 2017.

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## Are surgery services effective?

Good



We rated the surgery service as 'good' for effective. This was because:

- There were good patient outcomes across the heart and lung divisions.
- Care was delivered in line with relevant national guidelines.
- The average length of stay was short and there were low readmission rates across the service.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals throughout the patient journey.

### Evidence-based care and treatment

- The service contributed to the 'National Cardiac Benchmarking Collaborative' (NCBC).
- The pre-assessment service followed National Institute of Clinical Excellence (NICE), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and local guidelines to ensure appropriate pre-assessment of all patients prior to operations.
- Policies and treatment guidelines were available online via the trust intranet. However, the samples of these policies and guidelines we looked at did not appear to reference appropriate national or best practice guidelines.
- Nurses in ward areas we spoke with were aware of some regular audits, such as hand hygiene and environmental audits. However many nurses were not involved in carrying out any of these audits and had not received training on how to conduct an audit.
- Published information in international journals demonstrated evidence based care and treatment performed within the Royal Brompton Hospital surgical services.

### Pain relief

- All ward staff attended separate pain management and epidural study days to ensure competency in these areas.
- A nurse-led pain service was available Monday to Friday, 9am until 5pm. The on-call anaesthetist covered calls out-of-hours.

- Pre-assessment nurses identified patients who may require post-operative pain management support and were able to refer to the team for early intervention.
- The pain team received an award at the Pain Awards in 2015 due to their work in pain management for patients who had device insertions such as implantable cardioverter defibrillators (ICDs).
- The pain team had their own column within the nurse and surgical handover sheets. This was to promote continuity of care.
- The team had lectured staff regarding patients and their experience of chronic pain after thoracic surgery. This increased staff awareness of the chronic pain issues in this patient group and advised how to manage this.
- Nurses could attend study days which included subjects such as: physiology, pain psychology and the management of pain relief side effects. Staff learnt about the use of different pain relief methods. Staff on the ward stated that they had attended this training.
- The pain team had several joint clinics with other hospital services to assist with their chronic pain services. They attended weekly ward MDT meetings to ensure they were aware of potential referrals at an early stage.
- There was a range of leaflets for patients to take home including "Managing your pain at home after lung surgery" and "Managing your pain at home after cardiac surgery". These included contact information for the pain management team.

### Nutrition and hydration

- Patients admitted to hospital were screened using the 'Malnutrition Universal Screening Tool' (MUST). A dietitian saw all patients with higher MUST scores (two or more).
- Protected mealtimes were used, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions. We viewed protected mealtime audits which showed these were largely adhered to by staff.
- Dietitians were involved with patients who required supplemented feeding. They could order supplements to the ward for these patients.
- We observed a patient being assisted eating and drinking in a dignified manner. A red tray system operated on the unit to highlight to staff those who required help with eating and drinking.

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- Patients who were not allowed to eat prior to surgery were given intravenous fluids to ensure they remained well-hydrated. However, a recent audit into pre-operative fasting demonstrated the average fasting time for patients was 15 hours. The average time without fluids was five hours. This was much longer than recommended time of six hours for food and two hours for fluids. Staff showed us care plans implemented due to these audit results, which encouraged staff to ensure patients were able to eat and drink up until the required times before a procedure.
- Nutrition boards in the ward kitchens were updated daily with patients' specific needs. We observed housekeepers asking nurses if they were unsure of anything regarding a patient's nutritional status.
- Menus were available for those with specialist dietary requirements. On Reginald Wilson ward, these were available in Arabic.
- Patients told us that the food could have been better. This was a cause of patient complaints on a regular basis.

## Patient outcomes

- Monthly safety and clinical outcome reports were produced for both the heart and lung divisions which benchmarked services against national data and similar hospitals.
- Data from February 2016 demonstrated the Royal Brompton hospital (RBH) had a lower cardiac surgery risk adjusted mortality ratio (2.5%) compared with the national average (3.2%).
- In thoracic surgery, the RBH had a risk adjusted mortality ratio of 0.8% compared with the national average of 1.4%.
- The national Lung Cancer Audit in 2014 showed the trust scored better than the national average for patients receiving surgery. More patients received surgery (69.6%) than the national average (15.1%). However, the same audit found that the trust neglected to all discuss patients with the MDT adequately. They scored more than 70% lower in this measure than other national hospitals. However, during inspection we saw good evidence of MDT working.
- Readmission rates for RBH were lower than the England average for all specialities, in both elective and non-elective care.
- In the National Emergency Laparotomy Audit 2015, the hospital scored green (80-100%) for five of the ten measures audited, including consultant presence in theatres. The remaining six measures were rated as red (0-49%), which included the documentation of risk pre-operatively.
- The National Institute for Cardiovascular Outcomes Research (NICOR) data predicts operative mortality and is a measure of risk adjusted mortality rates for patients undergoing surgery. The last audit covered April 2011 – March 2014. The RBH were above the national average for the risk-adjusted hospital survival rate, scoring 97.9% against the national average of 97.7%.

## Competent staff

- Data demonstrated that 80% of nursing staff and 100% of health care assistants and administrative staff within the surgical services had an up-to-date appraisal. Nursing staff we spoke with told us their appraisal identified training needs and was based on trust values.
- Revalidation for nurses is a new scheme set by the Nursing and Midwifery Council (NMC) to support their professional practice. Staff we spoke to felt well supported in preparing for revalidation. There were education boards with information about this in clinical areas. There was also a trust lead.
- In theatres, there was a formalised training programme for all new scrub nursing staff who did not have previous cardiothoracic theatre experience. Staff either started within cardiac or thoracic services, with an assigned mentor who would support and assess their competencies. There was no fixed time scale for staff to complete these competencies. This was set depending on the individual. Healthcare assistants also had to complete competency booklets.
- There was no current practice development nurse (PDN) within the theatre department. This vacancy was currently being advertised.
- Anaesthetic trainee staff confirmed they had learning opportunities which included regular journal clubs, lectures and simulator training. However, staff told us anaesthetic trainees could sometimes feel undervalued when working within the department due to the consultant-led nature of the service. This was reflected in the GMC survey. The matter of trainees feeling undervalued had been addressed with educational supervisors and the GMC were satisfied with the response.

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- Clinical nurse specialists (CNS) had access to both national and international conferences. They told us there was a development programme in place, which included managing change and leadership education.
- Nurses on the ward told us they had access to weekly 30 minute teaching sessions. Topics included: equipment updates, wound dressing, feeding and patient controlled anaesthesia. They told us staff rotas were planned to ensure fair access to this training.
- Nurse practice educators were available on each surgical ward. They organised orientation to the wards for new staff and provided them with their competency booklets. They also spent time working with newly qualified staff to ensure they had sufficient support to complete their competencies.
- The practice educators ensured all staff were booked onto their mandatory training via the electronic learning management system. They helped staff to apply for additional courses such as mentorship and cannulation.
- The practice educators were also available to assist nurses wishing to apply for promotions by ensuring they had relevant experience.
- There were advanced nurse practitioners and clinical nurse specialists for thoracic and cardiac surgery. These nurses were highly trained staff who were able to take part in ward rounds and supported the ward staff to look after particularly unwell patients.

## Multidisciplinary working

- There was evidence of a multidisciplinary approach to patient care within the surgical services. Both doctors and nursing staff told us they worked well together and staff spoke highly of their cohesive approach to care delivery.
- The pre-assessment team worked well with anaesthetic staff and other specialist teams, both internally and externally, to provide coordinated care and treatment.
- Patients' records we reviewed demonstrated multi-disciplinary team (MDT) involvement in both patient care and treatment plans.
- Weekly cardiac and thoracic MDT meetings took place. During inspection we attended the aortic vascular MDT and noted good attendance from medical, surgical and radiology staff members. Local daily MDTs also took place in ward areas.
- Occupational therapists, physiotherapists, dieticians, pain team and complex discharge co-ordinators would attend MDT meetings each week on the different wards.

- A physiotherapist we spoke to told us that the hospital had "the best MDT working [she had] ever seen".

## Seven-day services

- Theatres, including anaesthetics and recovery areas, had staff on duty out-of-hours to cover emergencies. Theatre practitioners and anaesthetic support staff were on-call and told us they were usually available within an hour of being alerted of an emergency.
- Elective cardiac surgical operations were performed on Saturdays, but not on Sundays. Elective lists on a Saturday had a separate team of staff and were not part of the emergency on-call team.
- We found consultant cover was available seven days per week. The trust was part of the National Seven Day Services programme and were currently working to ensure compliance with this standard. We were told that a consultant saw all urgent patients within 14 hours of admission. Audit data provided demonstrated 94% compliance with this standard.
- The pharmacy service had recently been expanded to provide additional services on a Saturday. An on-call advice service was available on a Sunday.
- Dietitians were available Monday through to Friday. An on-call consultation service available on Saturday and Sunday. Nursing staff we spoke with told us they had never had to use the on-call service and told us they ensured all patients were seen on the Friday if there were concerns.
- Physiotherapy services were available seven days per week. Staff on the wards confirmed that they were available for advice and support when needed.
- Occupational therapists were available Monday through to Saturday. Staff on the wards agreed this cover was adequate, as all patients who had a planned discharge at the weekend would have arrangements in place by Friday.
- Perfusionist staff provided a seven-day perfusion service. The Society of Clinical Perfusion Scientists of Great Britain and Ireland (SCPS) guidance states the minimum safe number of accredited staff needed is one perfusionist per theatre, plus two extra. The theatres at RBH were not meeting this requirement out-of-hours.

## Access to information

- Staff had access to policies, procedures and guidelines on the trust intranet system. Staff we spoke with felt confident in accessing this information when required.

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However, staff also told us that there was sometimes difficulties in accessing information as the different IT systems used in the trust did not always communicate with each other.

- The discharge team worked closely with other health care professionals to ensure they had the necessary information so arrangements could be made for the patient prior to their discharge home or to another healthcare provider.
- Staff identified examples of how information was shared amongst the MDT, including morning handovers and weekly disease specific meetings.
- Patients were provided with information leaflets at their pre-operative assessment appointment. Information in the leaflet included preparing for your heart operation, pain management and dietary advice.
- In theatres, there was an electronic theatre list in the main reception. This kept staff informed of the theatre schedules. However, the list was not currently a live system and staff were unable to update it directly from the theatre. We were told the theatre co-ordinator would update this at regular intervals.
- A 24 hour helpline was available for patients to access information either pre or post-operatively. During our inspection, we heard a pre-assessment nurse responding to a patient who had post-operative concerns and issuing advice and reassurance via the helpline.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health (DH) guidelines.
- In 2015, audit data demonstrated that the operating consultant took consent in 42% of cases. We looked at three consent forms during our inspection, which were completed by clinical fellow staff. Post-operative patients confirmed they had signed their consent forms, were informed of what to expect and were given opportunities to ask questions. We reviewed three patients' consent documentation and saw that it was signed and dated. All risks explained prior to surgery.
- Detailed consent audits carried out in 2015 provided details of where improvements could be made when obtaining patient consent. These included ensuring abbreviations were not used and that patients were given information leaflets where available.

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was **not** part of the mandatory training programme however, we saw there were MCA and DoLS training sessions available monthly for staff to attend.
- Staff we asked did not feel confident in carrying out mental capacity assessments or completing Deprivation of Liberty Safeguards (DoLS) paperwork. However, they stated they had good support from clinical staff and could phone the safeguarding team if necessary.
- We reviewed one patient who was being nursed one to one. This patient had no mini mental score completed, no mental capacity assessment or DoLS paperwork completed. We raised this issue with the nurse in charge, who told us the high dependency unit (HDU) team were coming to complete this. When we went back later, it was still not complete.
- The healthcare assistant caring for the same patient recorded all care and patient behaviour onto continuation sheets. We reviewed this paperwork, which was completed thoroughly.

## Are surgery services caring?

Good



We rated caring as 'good' because:

- We observed the treatment of patients to be compassionate, dignified and respectful throughout the course of our inspection.
- Patients spoke overwhelmingly positively about their care and treatment. They told us staff were knowledgeable and that managers and matrons were available on the wards so patients and relatives could speak with them if necessary.
- Staff ensured that patients and relatives were involved in their care and that both patients' and their relatives' emotional needs were supported.
- Patients, their relatives, and carers were kept informed of their treatment plans and were given sufficient information to be able to support any decision making.
- Specialist nurses and practitioners were able to support staff in delivering complex information and to aid in patients' treatment. Patients could be referred to external counselling services if they required ongoing support.



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- We saw patient information leaflets and posters available for patients that explained procedures and aftercare arrangements.

## Compassionate care

- The Friends and Family Test (FFT) results were very positive for the surgical services (March 2015 – February 2016). Princess Alexandra Ward had scored an average of 98%, higher than the national average (96%) but did have a slightly lower response rate of 23% compared to the England average of 24%.
- The 2015 inpatient Survey scored 9.5/10 for care and treatment across the trust, this is better than the national average.
- We spoke to surgical patients on both Princess Alexandra and Reginald Wilson wards during the course of our inspection. Patients reported that the care given by the staff had been excellent, with one patient describing their care as 'more than excellent'. Many patients could not find any fault with the care they received and commented on the skills and knowledge of the nursing staff.
- However, one patient told us that that they had requested an escort to some diagnostic tests away from the ward, as he felt too unwell to go alone. The nursing staff on the ward told him he was well enough to go alone and they could not provide an escort. This patient's concerns were highlighted to the ward and there was no repeat occurrence.
- Patient's privacy and dignity was maintained. There were relative rooms available for private conversations and we saw curtains being pulled around bed areas when necessary.
- Senior nurses and matrons were proud of the quality and compassion of the care delivered by their staff. We saw evidence of many 'thank you' cards from patients displayed around the nurses' stations on wards.
- We heard the ward clerks speaking with visitors and telephone callers in a clear, calm and polite way.
- We followed a number of patients in main theatres during their procedures. We observed all staff interact with patients in a professional and pleasant manner. At all stages of the procedure, the patient was treated with dignity and respect.

## Understanding and involvement of patients and those close to them

- Patients felt well informed about their care and treatment and any proposed changes. Patients told us they had access to information while on the waiting lists for surgery via the 24 hour helpline.
- All patients said they were fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly.
- The families of patients that we spoke to felt they had been included in relevant discussions and that they had good access to information when required. They reported that they had also been kept informed of their relative's progress by telephone.
- Information boards and posters for patients, family members and carers were located at points throughout each ward. These included a guide to staff uniforms, photographs of the responsible matron, ward manager and nurses, and contact details for ward staff.

## Emotional support

- Patients had access to a psychiatric nurse specialist on site. They could facilitate a psychiatric doctor consultation and help patients access counselling services in the community if needed.
- There was access to multi-faith chaplaincy, seven days a week through a rota and on-call system. The team were clearly intuitive, caring and open to anyone who wished to speak with them, whether they had a religious belief or not.
- There were a number of clinical nurse specialists who supported patients before, during and after treatment. They were able to discuss specific concerns about procedures with patients and acted as a regular point of contact throughout the patient journey.

## Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement because

- Overall 75% of patients were treated within 18 weeks. This is above the national average for RTT however fell below the national indicator.
- There were high numbers of non-medical hospital cancellations.
- The trust was below the national average for treating patients within 28 days of a last minute cancellation.

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However

- The trust worked collaboratively with commissioners and other NHS trusts to plan and meet the needs of the population.
- The trust provided a number of services to improve outcomes for patients, including a 'one-stop' assessment and investigation facility.
- Patients had access to a 24 hour helpline for either pre or post-operative information and advice.

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

- The trust worked collaboratively with commissioners and other NHS trusts to plan and meet the needs of the local population. For example when appropriate follow up appointments were scheduled at a patients local hospital.
- The surgical services within both the heart and lung divisions were keen to demonstrate their national role within heart and lung specialist services. Data demonstrated that only 30% of their patients came from the local London area.
- The heart valve clinic ran every Thursday morning by clinical nurse specialists. It was available to all patients who had heart valve replacements. Patients would be assessed in the clinic once a year where appropriate tests would be carried out (such as echocardiograms, blood tests and chest x-rays). The clinic aimed to detect changes earlier in order to provide patients with effective care.
- The pre-assessment nurse-led clinic provided patients with a 'one stop' service where all required diagnostic testing was carried out during the same appointment visit. This prevented patients travelling to the hospital for multiple appointments. Patients would first have a telephone assessment to determine what testing was required.
- Regular events and conferences were held for patients with different diseases and conditions. For example, staff told us about the arrhythmia awareness week event which was held annually. There was also an implantable cardioverter defibrillator (ICD) patient experience day which occurred twice yearly.

- The structural heart disease care group held their first patient information day in November 2015, where 44 patients were invited. Topics covered included epidemiology, symptoms and treatment. Patient feedback from these events was hugely positive.

## **Access and flow**

- There were 4906 admissions to the service between September 2014 and August 2015. Of these, none were day case admissions, 89% were elective admissions and 11% were emergency admissions. Broken down further by speciality, 57% involved cardiac surgery, 43% were thoracic surgical procedures.
- The national referral to treatment (RTT) target is 92%. These targets monitor the length of time from patient referral through to elective treatment. Each patient has the legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate. The data provided by NHS England (April 2015 to March 2016) confirmed trust performance was above the national average, but still fell below the 92% national RTT standard. Up-to-date RTT data provided by the Trust (May 2016) demonstrated 71.50% cardiac and 100% of thoracic patients were treated within 18 weeks. Overall 79% of patients were treated within 18 weeks.
- The trust provided information which identified barriers in improving the RTT times. For example the trust told us that due to the complex nature of the surgery, only 1-2 patients can be operated on in a full day list and the availability of critical care beds.
- Information provided by the trust demonstrated that in order to reduce the number of patients waiting over 18 weeks, both hospital sites had undertaken extra (typically weekend) theatre lists. Between June and August 2016 an additional 27 patients underwent surgery in the extra theatre lists.
- Data provided by NHS England showed that cancellations of elective operations had increased substantially between April 2015 and March 2016. Theatre staff confirmed that any cancelled operations would be a priority on the next day's theatre list. We were told that the patient would not be discharged and the procedure would be carried out the next working day. However, data did not reflect this. The trust was below the national average for treating patients within 28 days of a last minute cancellation. Some staff we



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spoke with confirmed that patients would be discharged home if their operation was cancelled, which was frustrating. During our inspection, there were two operations on the theatre lists that had previously been cancelled and were therefore highlighted as a priority to be performed that day.

- Hospital episode statistic (HES) data from September 2014 to August 2015 confirmed the average length of stay for both cardiac, and thoracic surgery was higher than the England average. Cardiac surgery patients at RBH had an average length of stay of 16.9 days against the England average of 12.6 days. Thoracic surgery patients had an average length of stay of 8.9 days compared to the England average of 8.2 days. However, readmission rates were low.
- Preoperative patients were nursed on York ward. After an operation, they would be cared for on the intensive care unit (ICU), high dependency unit (HDU) or Princess Alexandra ward.
- During the course of the inspection, we heard one patient being told that there was no bed available for them on the ward. They were asked to rearrange their operation and schedule another date to come in. The ward manager told us this was not a rare occurrence.
- Bed management on the surgical wards was co-ordinated by a band 7 nurse. The medical team led an MDT discussion and elective admissions were organised by the scheduling team.
- The complex discharge team could be involved prior to an operation if required. Staff knew how to refer to the team if they had concerns over a patient's discharge needs.
- There were no estimated dates of discharge visible on the wards or printed on the handover sheets. However, we witnessed discharge planning being discussed during the nursing handovers.

## Meeting people's individual needs

- Single sex accommodation was provided in all clinical areas. There had been no single sex breaches in the previous twelve months.
- As part of a specialist trust, the Royal Brompton hospital treated patients from all over the country. The trust's three largest ethnic minority patient groups at the time of inspection were Indian (7.85%), Pakistani (2.87%) and Other Asian (2.96%). Staff were aware of how to access both telephone interpreting and face-to-face interpreting services.
- An oversight committee had recently been implemented to help improve care for patients with diabetes by developing and improving current policies and guidelines.
- On the wards we were told patients living with dementia were offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as possible. Red trays at meal times were used to alert nursing staff the patient may require extra help. Staff we spoke to had received in-house training on caring for people living with dementia.'
- Staff we spoke with in theatres told us there was no specific process to identify patients admitted with dementia or learning disabilities. One member of the nursing team told us there was an electronic flagging system available on the patient administration system. However, not all staff in the theatre department had access to this and the majority of patient care was documented on patient notes.
- We viewed the "Trust Dementia Strategy" which referenced the national dementia strategy. Objectives included enhancing the support of carers and developing a skilled workforce.
- Staff received training on how to care for those living with dementia. This was a one hour course. Staff could tell us about the "this is me" passport but could not find any in use on the wards.
- There was currently no lead nurse responsible for patients with learning difficulties due to staff sickness.
- The pre-assessment clinic asked patients living with dementia to bring a friend or relative with them to their appointment. This aimed to make the patient feel more comfortable and ensure all information was communicated properly.
- Staff wore "Hello, my name is..." badges. This campaign was started to ensure staff were introducing themselves to patients. Patients told us they found the badges helpful.
- The hospital chapel did have some Christian symbolism but welcomed people of all or no faiths. There was a separate small Muslim prayer room, separated by screens so men and women could use it at same time. Headscarves and prayer mats were available. The chapel and separate Muslim prayer room were open day and night for prayer or quiet reflection.
- The chaplaincy team provided spiritual support for different faiths. The team represented a variety of faith

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traditions (Church of England, Church of Scotland, Catholic, and Muslim), and were also supported by a number of pastoral volunteers and an out of hours on-call service.

## Learning from complaints and concerns

- We saw quality and safety meeting minutes from the lung division where both patient advice and liaison service (PALS) and formal complaints were discussed. Within the lung division there were 45 PALS concerns in 2015/16, an increase of six complaints from 2014/15. There were three formal complaints in the same period.
- Learning from local complaints was shared across the organisation through the Governance and Quality committee and the Risk and Safety committee. A quarterly Complaints Working Group (CWG) discussed cases where lessons were learned with wider implications which could then be shared across the trust. All staff were invited to quarterly workshops dealing specifically with complaints, where relevant and recurring topics were discussed in depth.
- The largest number of complaints and concerns were around appointments, delays and cancellations.
- Staff told us they were encouraged to deal with patient complaints and concerns through the trust LEAP (listen, empathise, apologise, provide a solution) system in the first instance.
- We saw posters and leaflets in all departments we visited encouraging patients to raise any concerns with staff and directing them how to make a complaint to PALS if necessary.

## Are surgery services well-led?

Requires improvement



We rated the surgery service at The Royal Brompton Hospital as 'requires improvement' for well-led. This was because:

- New leadership structures within the theatre department were not fully embedded at the time of inspection. Friction between different staff members, who were managed by different leaders, was apparent.

- Although the working culture had improved across the theatre department, staff still reported perceived bullying and harassment in theatres. Staff told us they felt undervalued and disrespected by some of the surgeons.
- We heard of staff being shouted at and humiliated in front of their peers by the management team in theatres.
- Risk registers were available at divisional level however staff on both the surgical wards and in theatres were not aware of what risks were listed on the risk register.

However

- The surgery services had the processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant.
- There are high levels of staff satisfaction across all equality groups in the ward areas of the surgical services.
- Staff within the surgical services were proud of the work they carried out in the hospital. Staff told us they felt confident that they provided excellent patient care and treatment through MDT working.

## Leadership of service

- The cardiac and thoracic divisions were led by a divisional director, divisional general manager and divisional nurse manager. Divisions were split into disease groups which each had their own governance structure.
- The surgical nursing structure included matrons, wards managers. Senior nursing staff including matrons told us they carried out daily walk rounds of patients and the units to ensure they were aware of any patient and staff issues or concerns.
- Nursing staff on the wards were positive about the general leadership and management of the service. Senior nurses told us they had support from the divisional management team to drive forward change and improvement. Junior nurses told us they felt supported to learn and develop within their roles.
- On Princess Alexandra ward, the charge nurse was visible and assisting junior staff to care for patients and administer medication. Staff commented that senior nurses were supportive during busy periods.

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- The management of theatres had recently been revised and there were new staff in post. There was now a matron to work across both the theatres and the catheterisation labs. This aimed to improve the culture, as well as patient safety and patient flow. However, the theatre manager did not manage the operating department practitioners or the staff in the recovery area and we heard from staff that there was on-going friction caused by this.
- During the course of our inspection, theatre management processes appeared to cause friction amongst staff. Staff told us they felt that change was being pushed forward without their involvement. Staff told us and gave examples of when theatre practitioners were shouted at and humiliated in front of their peers and colleagues by the management team.
- Staff on both York Ward and Princess Alexandra ward said the matron visited regularly to meet patients and ensure care needs were being met. She would ask staff if there were any issues. One HCA told us that new linen baskets were ordered because of her suggestion.

## Vision and strategy for this service

- Leaders of individual surgery service lines were able to articulate a long-term vision for developing their services.
- Staff were familiar with the trust vision of being the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world. They were committed to helping patients when others could not.
- The Nursing Strategy for 2015-2019 was visible at the nursing stations, along with both the ward and trust visions.
- Staff were able to identify the three trust values as "we care", "we respect" and "we are inclusive".
- There were priorities put in place every three years to contribute in working towards the trust vision. Current priorities included reducing falls, improving management of the deteriorating patient and improving medicines management.
- Staff told us there was a 360 degree feedback system in use. This meant that all staff received anonymous feedback, focused around the trust values, from people they worked with prior to their yearly appraisal.

## Governance, risk management and quality measurement

- The surgical services at RBH sat within the heart and lung divisional groups. Each division was then divided into sub specialty care groups focused around a specific disease. Each care group monitored their own performance and risks.
- Clinical governance structures were in place across each service. Senior staff we spoke with said they were effective. Each division held quality and safety meetings to discuss performance, risk management, complaints and incidents. The lung division met quarterly, whereas the heart division met more frequently, about once every six weeks. Meeting minutes demonstrated consistent attendance from senior leadership and senior clinician teams.
- Monthly ward meetings took place to share information with nurses and health care assistants (HCAs) on the wards. Staff did not record minutes for these meetings. However, nurses told us they discussed incidents (both local and trust wide) and any learning from these, performance and upcoming learning opportunities. Managers told us that improvement ideas were discussed at these meetings.
- Quarterly nurse specialist meetings took place. Once a year, these were conducted cross-site to network with specialist nurses at the Harefield site. These meetings were used as a forum to discuss changes, developments and improvements across the services.
- Monthly theatre user group meetings took place. In these meetings, staff were encouraged to raise and discuss any issues which could be taken forward to the monthly governance meetings to improve theatre working.
- Ward managers and the surgical matrons attended monthly cross-site meetings to discuss quality and governance issues. There was a monthly ward sisters' meeting specifically to discuss incidents. The clinical risk lead for the hospital attended this meeting to ensure that learning points were discussed.
- Patient safety and clinical outcomes monthly reports were available for each division. These monthly reports included information about mortality, surgical site infection and friends and family test information.

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- Performance dashboards were available for the theatre department on the trust intranet. The dashboard displayed a range of information, including session usage for cardiac and thoracic cases and the numbers of cancelled operations.
- Risk registers were available at both trust and divisional level. We were told that relevant trust risks were also added to the divisional risk registers. Staff in both ward areas and in theatres were not aware of any items on either risk register.
- Monthly mortality and morbidity meetings took place as part of clinical governance days. We were told that mortality rates were tracked per clinician. The trust gave examples of actions taken when there were concerns. Clinicians used a peer review system when looking at cases.
- We saw both individual surgeon and patient profile reporting was used to track and monitor survival and mortality rates. Meeting minutes demonstrated that these reports were risk adjusted so that surgeons who were doing more complex and higher risk procedures are not disproportionately affected.
- Monthly clinical governance meetings were also held. In theatres, all elective activity would stop so staff could attend. Senior staff on the wards made rota adjustments to ensure staff could attend. Staff told us that previous clinical governance meetings were useful as they provided an opportunity to discuss departmental performance and improvements.

## Culture within the service

- Staff within the surgical services were proud of the work they carried out in the hospital. Staff told us they felt confident that they provided excellent patient care and treatment through MDT working.
- In the 2016 staff survey, most staff reported that they would recommend the hospital as a place to work (the trust scored 4.21 out of five). This was better than the national average for specialist trusts (4.17 out of five).
- Prior to inspection information was provided through the staff survey, focus groups and written correspondence that raised awareness and concerns about the culture within the theatre department. During the course of our inspection, staff reported difficulty with a group of surgeons in theatres. One nurse we spoke with told us improvements had been made to ensure nurses felt more empowered. However, the

majority of nurses we spoke with felt pressured to stay late after the end of their shifts. Most also felt surgeons were disrespectful towards them or had witnessed when surgeons had been disrespectful to others.

- Improvement initiatives were in place to combat these issues, in theatres. These included the restructuring of appraisals to include discussions around behaviour and 360 degree questionnaire appraisals, which sought feedback from different members of the team.
- There was a confidential helpline available 24/7 to staff who felt they were being bullied or harassed. Staff in theatres had been encouraged to report this behaviour.

## Public and staff engagement

- Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed within divisional meetings and were available to view in ward and theatre areas.
- The trust had links to a number of organisations to provide additional support and advice to patients and carers. These included: The Royal Castle Lung Cancer Foundation, Macmillan Cancer Support and the Princess Royal Trust for Carers.
- Staff were keen to tell us how they had been involved in improvements within their service. Doctors, nurses and other members of the MDT gave examples of contributions to both patient care locally and national policies and guidelines.
- The heart division held patient information days, organised by consultants and specialist teams. These included days on topics such as adult congenital heart disease and structural heart disease. Feedback from patients was very positive. One attendee commented, that it was an 'invaluable day' and thanked the team.
- Patient feedback was shared at ward meetings. Staff told us that this was motivational. We also saw boards in staff areas containing 'thank you' cards from patients.







## Innovation, improvement and sustainability

- The Brompton and Harefield Infection Score Intervention Package (BHIS-IP) had been awarded a Society of Cardiothoracic Surgery gold medal after reducing infection in coronary artery bypass surgery.

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- There were ongoing improvements to systems to strengthen links between acute and community care providers. A photo on discharge (PAD) system had contributed to a reduction in surgical site infection rates.

# Critical care

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

## Information about the service

Critical care services at the Royal Brompton Hospital consist of a 20 bed adult intensive care unit (AICU) that provides level three care and a 16 bed cardiothoracic high dependency unit (HDU) that provides level two care. There is also a recovery unit equipped to provide level three intensive care and level two high dependency care if the main units are full and five respiratory medicine HDU beds on Victoria ward. The AICU has four bays with four beds each and four side rooms and the HDU has three bays and six side rooms.

At the time of our inspection the AICU had a reduced capacity of 10 beds due to an infection outbreak.

Patients are admitted to the units most frequently as an elective admission after surgery although the units are equipped to treat patients admitted in an emergency. There is a side room in HDU that is dedicated to patients admitted in an emergency through a local service agreement with two other trusts.

Critical care services are equipped and staffed to provide care to patients using extracorporeal membrane oxygenation (ECMO). This treatment is used where a patient needs mechanical support for both their heart and lungs. The hospital treats up to 60 ECMO patients per year.

Between June 2015 and June 2016, AICU treated 4308 patients with occupancy of 84%. During the same period, the HDU treated 2306 patients with occupancy of 82%.

The AICU and HDU operate with separate local governance structures and nursing teams but share a common clinical

director and some doctors work between both units. A highly involved team of healthcare practitioners, including physiotherapists and dieticians, provided therapeutic support to patients.



# Critical care

## Summary of findings

**Overall, we rated critical care at the Royal Brompton Hospital as requires improvement because:**

- Incident reporting was embedded into the culture and practice of critical care and there was some evidence of learning from this. However, not all clinical staff we spoke with were confident in the process or felt incidents they reported were dealt with appropriately.
- There were failures in local infection control effectiveness. This included variable hand hygiene audit results, inconsistent nurse practice and inadequate handling of intravenous fluids.
- The hospital did not have a critical care outreach team. A similar service was in development through the creation of night practitioner roles for senior nurses and daily ward 'sweeps' conducted by the HDU matron and other nurses.
- Significant changes in management and communication from the senior team in the AICU had resulted in problems with staff morale. There was limited evidence the senior team had addressed this from our interactions with staff and 13 individual members of staff told us they felt very unsupported in the unit. Clinical governance was evident but had failed to address on-going staffing concerns.
- The supervision and opportunities for development and training of junior doctors had deteriorated because nine consultants had departed the AICU in a short space of time.
- Medicines were stored securely but the temperature of the high dependency unit (HDU) meant ambient medicines were stored above the safe maximum temperature recommended by the manufacturer. After our inspection the trust provided information that demonstrated an appropriate risk assessment and mitigating processes were in place to minimise risk.

**However:**

- Nurse and medical staffing levels consistently met the requirements of the Royal College of Nursing and the Faculty of Intensive Care Medicine.

- Safeguarding practices ensured patients and their relatives were kept safe from harm, including from abuse and exploitation.
- There was a good track record in providing harm-free care, including in the avoidance of falls, urinary tract infections and pressure ulcers.
- The number of nurses with a post-registration qualification in intensive care medicine exceeded the minimum requirement of the Royal College of Nursing.
- Care and treatment was provided in line with national and international best practice guidance. Critical care services were working towards more robust national benchmarking.
- Outcomes for patients who were treated with extracorporeal membrane oxygenation were significantly better than international averages.
- Patients and relatives said they felt staff were compassionate and very caring.
- A dedicated team of clinical educators was highly regarded by staff and provided on-going teaching and learning opportunities, including through the use of simulation technology.
- Staff were given opportunities to develop professionally, including through leadership pathways and participation in quality improvement work.
- Support and services were available for patients with dementia, learning disabilities and communication needs, including translation. A range of multidisciplinary specialties were available, including physiotherapy, dietetics, occupational therapy, pharmacy, psychology and microbiology.
- After our inspection the trust provided us with details of the support offered to junior staff following the changes in the consultant team. This included the appointment of an additional faculty tutor and processes in place for pastoral support.



# Critical care

## Are critical care services safe?

Requires improvement



### We rated safe as requires improvement because:

- There was an embedded and robust incident reporting system and culture in place with some evidence that incidents were investigated. While some staff felt this process was effective, some individuals gave examples of poor dissemination of outcomes and some of the incidents demonstrated ongoing communication problems between teams. After our inspection the trust told us each member of staff received feedback after an incident investigation was completed. It was not clear why some staff were unaware of this or told us it had not happened in their case.
- A fungal bacterial outbreak of candida auris had affected 14 patients between April and June 2016 and had resulted in the closure of part of the adult intensive care unit (AICU). Although clinical educators and the senior team had significantly increased infection control training and monitoring, the unit had a track record of variable and sometimes poor practice in hand hygiene compliance and the use of personal protective equipment. Processes were in place to contain the outbreak, including decontamination, environmental refurbishment, the implementation of new policies and weekly operational and strategic meetings.
- We found infection control practice on the HDU to be compromised by the reuse of single-use intravenous saline fluid.
- Medicines management overall was good, with evidence of learning after mistakes and input from pharmacists. However, the storage of medicines was problematic because ambient temperatures often exceeded the maximum allowed by pharmaceutical manufacturers. This meant the medicines might not be as effective. Staff we spoke with were unaware of action to correct this. After our inspection the trust provided a risk assessment and details of strategies to mitigate the risk.
- Knowledge of safeguarding principles and protocols was good overall and staff demonstrated an innovative approach to protecting vulnerable patients. However,

some staff had limited knowledge of this and some said they had not undertaken training although training figures indicated 97% of staff had up to date adult safeguarding training.

- Supervision of junior doctors on the AICU was inconsistent and not always fit for purpose. Engagement with junior doctors was variable and unpredictable. After our inspection the trust told us structured education and supervision was in place for junior doctors and it was not clear why there were differences in understanding of this.
- Although there were processes in place to manage deteriorating patients in critical care and elsewhere in the hospital overnight, including on-call registrars in anaesthetics, there was no dedicated permanent critical care outreach team.

### However:

- Nurse and medical staffing levels met the requirements of the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units and the Royal College of Nursing.
- Clinical educators implemented increased training and monitoring to improve hand hygiene in response to falling standards of practice. This included additional audits and inclusion in daily safety briefs.
- Clinical educators and the HDU matron established processes to manage deteriorating patients in critical care and elsewhere in the hospital. In addition a new night practitioner role was being piloted for a senior critical care nurse to conduct 'sweeps' of medical wards out of hours to monitor patients with high acuity.
- Established emergency and major incident processes were in place. Staff had participated in a full simulated evacuation that included smoke-filled areas and assessed evacuation of intubated patients. Evacuation plans had been updated to take into account the partial closure of the AICU although some staff we spoke with were unaware of this.

### Incidents

- Staff used an electronic system to report incidents. There was a system in place to ensure an appropriate person investigated and actioned the incident report. Initially this was the responsibility of the nurse in charge on the shift in question and the clinical educators, senior nurses or matron could provide additional support.

# Critical care

- Between April 2015 and March 2016, 222 incidents were reported in the adult intensive care unit (AICU). During the same period 12 incidents were reported in the high dependency unit (HDU).
- There was evidence of learning and changes in practice following incidents in some cases. For example, following an instance of catastrophic blood loss, staff found the process of calling haematology by phone and then waiting for a call back problematic because of the noise in the unit associated with the emergency. In this instance, the nurse responsible for liaising with haematology missed the call because they could not hear the phone. As a result, senior staff provided new portable handsets and changed the policy that meant roles were more defined, such as allocating one nurse to communication.
- A multidisciplinary team of 27 staff, including consultants, nurses, a pharmacist, psychologist and therapy lead formed a quality and safety committee for the AICU. We looked at the minutes of three meetings and found discussions around incidents to be robust and detailed, with clear outcomes established.
- Four members of staff said they didn't feel incidents were always taken seriously enough by the senior team. For example, a post-surgical patient had been admitted to the HDU in a bed space whereby the previous patient had tested positive for a fungal infection. A nurse submitted an incident report relating to this, as the staff member felt that there was an increased risk of mortality that had been caused. They told us they felt the generic response received had failed to address the risk that had been caused. After our inspection the trust told us this situation had been risk assessed, the patient's family informed and clinical decisions made in their best interest.
- Some clinical staff raised concerns with us about the handling of incidents. For example, one member of staff said they had submitted an incident report when a patient with flu was treated in an open bed bay instead of in a side room. They felt this was not addressed appropriately by the senior clinical team. Another member of staff said a patient had experienced a cardiac arrest when a locum consultant inexperienced with extracorporeal membrane oxygenation (ECMO) treatment had turned their oxygen flow down. None of the staff we spoke with could tell us the outcome of the incident or if learning had taken place.
- The quality and safety lead, matron or deputy matron and a clinical educator offered twice-monthly governance sessions to AICU staff. The sessions were used to discuss the outcomes of incidents and how this could be avoided in the future. However, it was clear from some of our conversations that staff had not fully engaged with this process or were not able to access it.
- From April 2015, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Senior clinical staff understood their responsibilities under the Duty of Candour. This included being open and honest with patients and relatives in the event something went wrong and using the incident as a learning opportunity. For example, when a junior nurse had made an error with an incorrect dose of morphine, the analysis of what went wrong was shared with the patient and with staff during team days. This helped staff to be mindful of common causes of mistakes when giving medicine. Associated health professionals who worked closely with patients also demonstrated an understanding of this.
- Incident investigations were not always shared with staff promptly. For example, two senior AICU nurses were unaware of any serious incidents in the 14 months prior to our inspection. However, the trust had reported three serious incidents for critical care. Two related to pressure ulcers and one remained unclassified.
- Consultants led a monthly morbidity and mortality meeting. The meetings were attended by multidisciplinary senior clinicians and each patient death was discussed and assessed for improvements in practice.

## Safety thermometer

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- Staff in critical care contributed to the NHS Safety Thermometer programme. Information was collected on a monthly basis and clear, easy-to-read information was displayed for staff, patients and visitors.
- AICU tissue viability link nurses had been established to carry out audits on pressure ulcer avoidance and care. This team had established pathway to care for patients who were admitted with a pressure ulcer of grade two or above. This included a bedside meeting with a tissue viability nurse to prevent the pressure area from deteriorating further.
- Between January 2015 and December 2015, there were no cases of unit-acquired pressure ulcers, falls or catheter urinary tract infections.

## Cleanliness, infection control and hygiene

- The trust told us that the bed capacity of the AICU had been reduced to 50% for two weeks in response to the candida auris infection outbreak, the source of the infection was unknown. Senior clinical staff met with NHS England infection control teams twice weekly to monitor and follow up with affected patients. A microbiologist supported the clinical team on a daily basis to identify and try and prevent new cases. Between April 2016 and June 2016, 14 cases of candida auris had been identified by the trust. An independent external consultant had been engaged to undertake an investigation and refurbishment to remove wood benching, floor and wall surfaces was undertaken. In addition, unit-wide decontamination took place.
- The clinical director was working to establish an antifungal stewardship programme. This is a programme that consists of multidisciplinary interventions by infection control specialists according to guidelines set by the Centers for Disease Control and Prevention in the United States. As this health authority had more up to date data on the spread and prevention of candida auris, staff used this guidance alongside information from NHS England.
- Some patients had been transferred to the HDU at the beginning of the outbreak in response to the AICU partial closure. In the HDU patients could be cared for in side rooms using barrier nursing methods. The closed section of the AICU unit was sealed and undergoing decontamination at the time of our inspection.

Additional personal protective equipment (PPE) had been supplied for staff to use and clinical educators had worked with infection control specialists to encourage staff to follow strict cleanliness protocols.

- During our inspection a member of staff asked to speak with us about infection control standards. They were concerned that porters disposed of hazardous waste from critical care during the same shifts in which they moved patients around the hospital. This presented a risk of cross-infection unless infection control procedures were followed. In the portering team, 30% of staff had infection control training. After our inspection the trust took action and by August 2016 all porters had up to date hand hygiene training. Personal protective equipment was also introduced at this time.
- Staff worked with Public Health England to ensure the repatriation of patients to their local hospital critical care was completed without risk of spreading infection. However, clinical staff told us some patients had been discharged before staff received the positive results. This meant it was not clear if appropriate containment protocols had always been followed during the repatriation. After our inspection the trust provided evidence that all positive patients were identified before discharge and subsequently tracked according to a management protocol.
- A senior member of staff conducted a root cause analysis of each case of candida auris that colonised a patient to identify if staff could improve vigilance of or practice in infection control.
- Clinical educators provided additional training and bedside support for staff to help ensure infection control procedures were followed. This included reassessing staff for their use of the aseptic non-touch technique for intravenous therapy and the use of an ultraviolet light box to assess the effectiveness of hand washing. This had resulted in higher levels of compliance with hand hygiene audits, which had improved from 50% six months prior to our inspection to 91% in May 2016 and 82% in June 2016. Seven nurses we spoke with told us they felt confident in maintaining more robust infection control because of the extra training and supervision given.
- The trust's minimum hand hygiene compliance standard was 90% and this was audited monthly using a

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five-point check. This included hand washing before and after specific tasks, including patient contact as well as compliance with the bare below the elbow policy. From July 2015 to March 2016, the HDU had an average compliance of 93% with hand washing and 100% with bare below the elbows adherence. In the same period, the AICU had an average compliance with hand washing of 79% and 98% with bare below the elbows adherence. There were some areas of significant concern with hand hygiene in the AICU. Between October 2015 and December 2015, nurse compliance with hand hygiene overall was 64%. This included only 20% compliance with hand washing after taking bloods or handling bodily fluids. Although compliance for this factor improved to 88% in the following quarter, this was still below the trust's minimum standards and two other measures fell. This included a reduction in hand washing before patient contact, from 64% to 59% and hand washing after patient contact from 75% to 53%. This meant there was a high and sustained risk of poor infection control.

- A full infection control audit had taken place in the AICU in January 2016. This found staff still failed to follow hand washing techniques correctly or consistently. It also found that basic information on hand washing was not always available, such as World Health Organisation posters above each sink. During our inspection we found posters had been provided and saw antibacterial gel was provided at the end of each bed space. In addition, the unit administrator provided relatives with an orientation that included the principles of hand hygiene and the bare below the elbows policy.
- Infection control staff completed an audit of the use of PPE when caring for patients with carbapenem resistant enterobacteriaceae, a type of bacterial infection resistant to antibiotics. The audit found inconsistent adherence to the correct and safe use and disposal of PPE. The audit also found that a member of staff used their mobile phone in the patient's vicinity whilst wearing PPE. An immediate requirement for staff to be reminded of the mobile phone policy was issued.
- In response to the candida outbreak, senior staff undertook an audit of nurse technique in bed bathing, specifically their use of a detergent solution. The audit highlighted broadly good practice and also identified

some areas for improvement, such as leaving the detergent on the patient's skin for longer and the need for an education session from the detergent manufacturer to optimise use.

- Staff in AICU said a new policy of storing intravenous fluids in a locked cupboard caused delays to treatment and posed a safety risk. For example, one nurse had needed IV fluids urgently but the key to the cupboard had not been returned to the correct place. This resulted in a delay in obtaining fluids. They told us they had escalated this and had not received a constructive response. After our inspection the trust implemented a new code access system to fluids that meant staff did not need to find a key holder.
- Disposable curtains had clearly marked expiry dates and all of the curtains we saw were within their shelf life.
- Infection control staff undertook monthly environmental cleaning audits. The trust minimum standard for the audit was 98%. In May 2016 the AICU achieved 94%.
- We found staff on HDU sometimes reused single-use intravenous saline fluid bags. This presented a significant infection and contamination risk and was in breach of nurses' Nursing and Midwifery Council registration and against manufacturer's guidance about single use products. We brought this to the attention of the nurse in charge who said they would ensure the practice stopped.

## Environment and equipment

- Both the AICU and HDU had side rooms used for barrier nursing patients who were infectious. However, the rooms did not have facilities for negative pressure air flow. This meant infection control risks could not be fully managed. The HDU matron had implemented a new process to try and mitigate the risks associated with this. For example, staff conducted only essential conversations in side rooms and promoted decision-making outside of the room. This reduced the time they needed to spend in the room and helped to streamline the treatment and care at the patient's bed side.
- Junior doctors did not have a dedicated space for teaching, learning and meetings. Doctors we spoke with

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said this was a concern because there were more than 20 junior doctors working in critical care and they needed a space to be able to meet, which the trust had not provided.

- The HDU unit did not have adequate ventilation or air conditioning. Staff told us they monitored temperatures during the summer months and temperatures were typically between 28 degrees Celsius and 35 degrees Celsius. The trust had fitted window blinds and provided bedside fans for each patient to reduce discomfort. When the temperature exceeded 28 degrees, nurses were permitted to wear loose-fitting scrubs to reduce body sweat. However, staff raised concerns with us about this. They said it was difficult to maintain hygienic treatment conditions when wearing PPE because the heat of the unit was so high the protective items resulted in them sweating more.
- We checked all resuscitation trolleys in critical care areas, including emergency drugs, airway equipment, defibrillators and oxygen masks. Staff documented equipment checks twice daily and checked the expiry dates of medicines on a weekly basis. Where an item was defective or approaching its expiry date, corrective action had been taken.
- A side room in recovery could be used as a 21st bed for the AICU and was equipped for nurses to provide level three care.
- A biomedical mechanical engineering (BME) team provided support on-site 24-hours, seven days a week. This team ensured equipment was serviced and helped to source additional clinical equipment.

## Medicines

- There was an electronic prescribing system in place and drug allergies were clearly recorded in all 10 of the patient records were looked at.
- Medicines, including controlled drugs, were securely stored in automated cupboards that only trained staff could access using a biometric and password system. Staff documented daily stock checks on controlled drugs. In the six months prior to our inspection, there were no missing daily checks for AICU and three missing daily checks for HDU. There were no stock or prescribing discrepancies.
- We checked seven medicines charts and found they were appropriately checked by the pharmacist and in accordance with guidance and recommendations.
- A dedicated critical care pharmacist attended the weekly multidisciplinary ward round. They also provided some clinical pharmacy support to theatre recovery staff such as reviewing patients before they were transferred to the AICU or HDU. This ensured medicine was appropriately managed.
- Appropriate guidelines were in place to ensure safe administration of medicines and staff had easy access to them.
- The critical care pharmacy team managed the drug library used for infusion pump administration, which meant treatment was delivered safely.
- Staff recorded daily temperatures for the storage areas of medicines, including refrigerated medicine. Medicine storage areas were not always maintained at an appropriate temperature. On one day of our inspection a medicine storage area was recorded as 27.5 degrees Celsius. This exceeded the maximum storage temperature of 25 degrees Celsius recommended by medicine manufacturers. We asked a nurse about this. They said when the temperature exceeded the maximum allowed; a member of staff submitted an incident report and contacted the on-call pharmacist. We looked at the temperature records for June 2016 for this area. Temperatures were missing for seven days and the temperature exceeded the maximum recommended on 16 days. This meant there was a risk medicines would not be fully effective. There was no documented evidence on the recording charts of corrective action taken. After our inspection the trust told us pharmacy staff identified not all medicines used in critical care needed to be stored below 25 degrees Celsius. They also provided evidence that showed a rapid stock rotation system meant medicines were stored on the units for the shortest amount of time possible and a new data collection programme was in place to assess the safe temperature range of medicines.
- Nursing staff were able to describe action they would take in the event of a medicine error. They also gave examples of learning and actions from previous incidents that resulted in better outcomes for patients. For example, after a documentation error relating to a



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controlled drug, clinical educators and a pharmacist worked with staff to ensure they followed correct procedures. Action was documented in monthly clinical governance documentation and there was evidence of improved communication between prescribing clinicians and the pharmacy team as a result.

- A medicines safety team was in place for critical care services and was supported by pharmacists. This team delivered medicines training updates during team days.

## Records

- An electronic patient records system was in use in critical care areas. This ensured consistency of recording observations, diagnoses and test results when patients moved between AICU and HDU.
- Staff completed risk assessments and observations electronically. This included mouth care, tissue viability, delirium, waterlow, physiotherapy, nutritionist, neurology observations, ventilator checks, intravenous line checks and an infection control review.
- Staff had not always completed risk assessments for venous thromboembolism (VTE). VTE risk assessments were missing in two of the four patient records we looked at in HDU.
- Time-critical observations, such as hourly or two-hourly were recorded consistently and accurately.

## Safeguarding

- Safeguarding training was part of the trust mandatory requirement. In critical care, 77% of staff had completed safeguarding adults level one; 81% safeguarding children level one and 23% safeguarding children level two. Most of the staff we spoke with were able to explain their understanding and responsibilities in relation to safeguarding. Two clinical members of staff said they did not think they had been given safeguarding training and could not explain their role in this area.
- The trust provided 'PREVENT' training in line with Home Office guidance on preventing radicalisation. In the HDU, 60% of staff had completed this training.
- Critical care units provided care for patients from 16 years old. Where a patient was admitted between the ages of 16 years old and 18 years old, they were cared

for by staff with a minimum of safeguarding children level two training using a specific pathway that ensured they were cared for in a side room. A parent was always able to stay with them.

- Staff developed innovative ways of ensuring vulnerable patients were safeguarded from harm or abuse. For example, where a patient was planned to be admitted and had a history of domestic violence, AICU staff worked with social services to discuss how they could obtain consent for treatment or for visitors whilst they were unconscious. Staff also established ways to monitor who visited the patient. Staff also implemented password systems for phone calls from relatives so that only people who the patient had authorised staff to speak with could obtain information.

## Mandatory training

- Clinical educators worked with staff to plan their mandatory training. Much of this was delivered electronically and some staff told us it was not possible to complete this in paid work time as they were too busy. Staff were offered time back when they had to complete online learning out of work hours.
- HDU staff mandatory training completion rates were 38% for dementia care; 83% for fire safety; 62% for infection control; 77% for equality and diversity; 72% for medicines management and 81% for moving and handling.
- The hospital's infection control team delivered training at each quarterly team day to supplement mandatory training.

## Assessing and responding to patient risk

- The hospital did not have a permanent critical care outreach team (CCOT). Staff used the national early warning scores (NEWS) system to assess deteriorating patients and were able to call AICU staff for advice. This was not a formal system or process but clinical educators were able to attend to requests for help from ward nurses. Overnight, site practitioners liaised with doctors on the HDU for support in treating deteriorating patients. Ward nurses had NEWS training and were able to support patients who deteriorated using a specialised pathway. Critical care clinical educators provided training across the hospital in the management of escalating inotropes.

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- To mitigate the risks associated with the decrease in available AICU beds, senior nurses had formed a temporary CCOT service with the HDU matron. This team conducted regular ward sweeps with an intentional rounding tool to identify patients with increasing NEWS scores who might be at risk of deteriorating. The team also monitored patients who received inotropes, had unmanaged arrhythmia and who needed hourly observations. This meant the team could arrange critical care admissions in advance around reduced bed availability.
- A new night practitioner role had been implemented as a pilot programme to address the lack of permanent CCOT. Three senior HDU nurses worked in this role and provided out of hours cardiothoracic support to staff on wards caring for deteriorating patients. Staff in this role could cannulate patients and were being developed to be able to prescribe in the future.
- The patient risk nursing quality group had completed work to improve how risk was managed in the HDU from a nursing perspective. As a result, a daily safety briefing had been implemented. This took place as part of nurse handovers and included a discussion of each patient's risks. For example, staff used this to help them decide if it was safe to help a patient to walk to the toilet or if they needed a bedside commode instead.
- Critical care services had a restraint policy in place but staff we spoke with had variable understanding of this. For example, staff did not always understand when or how a patient might need to be restrained, for the protection of either person. During our inspection a member of staff raised concerns about the frequency with which patients in the HDU were physically restrained. They said this had happened twice in the previous six months and had required multiple staff to attend, including security staff. We asked the trust to provide details of instances of restraint but were told there was no record of the events. Security staff were called to the HDU on 13 occasions in the previous 12 months due to confused or aggressive patients. However, security staff did not have formal restraint training and not all staff had received appropriate training. For example, 50% of security staff had safeguarding training and only 25% had infection control training.

- Staff received life support training at a level in line with their clinical responsibilities. This included basic life support training for all staff, intermediate life support training for band six and advanced life support for band seven nurses. On the HDU, 74% of required staff had up to date BLS training, 34% had up to date ILS training and 17% had up to date ALS training. On the AICU, 94% of staff had up to date BLS training.

## Nursing staffing

- Nurse staffing levels met the requirements of the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine's (FICM) Core Standards for Intensive Care Medicine. A nurse to patient ratio of 1:1 was maintained for patients in the AICU and a ratio of 1:2 was maintained in the HDU. Where a patient was treated with ECMO, the nurse to patient ratio was increased to 2:1.
- Both the AICU and HDU had supernumerary nursing staff on each shift, including the nurse in charge and a runner. This met and sometimes exceeded the required nurse staffing levels from FICM and the RCN.
- Some nurses took part in a rotation programme that enabled them to work in the HDU and the medical inpatient wards. This was completed within an established programme of development and nurses had access to clinical educators for progress.
- A matron and a specialised senior sister led the HDU and a matron and deputy matron led the AICU.
- A 'runner' was scheduled for every shift in both units. This individual was able to liaise between staff on the shift and ensured rapid communication between the nurse in charge and the staff working in bays and side rooms. This meant the nurse in charge maintained oversight of the unit despite the difficulties associated with bays and side rooms being spread out and not visible at the same time.
- Nurses' handovers took place twice daily. During this time, the nurse in charge delivered a four-point safety briefing relating to the specific unit. This included items such as updated or new policies, a reminder of a clinical pathway or an introduction to a new member of staff. Senior staff said this was a new addition to the handover process to try and reduce the reliance on e-mail communication.



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- A team of clinical educators ran an induction programme that supported nurses who came to work in critical care from medical wards and from overseas recruitment programmes. Part of the induction programme also included ventilation and tubing training in a simulation suite.
- Where the additional bed in recovery was used by a critical care patient, this was staffed on a nurse ratio of 2:1. This enabled one nurse to act as a runner between recovery and the AICU.
- HDU beds on Victoria ward were always staffed following a nurse to patient ratio of 1:2.
- During the inspection period AICU introduced a new nurse role. This was a senior staff nurse on call for ECMO patient retrievals. Nurses in this role had ECMO training and were working to establish the scope of the position.
- On AICU, the deputy matron held a daily safety huddle to identify any patients with unusual or significant risks.
- A team of healthcare assistants (HCAs) were able to support nurses clinically and also worked in a procurement role. The HCA role was not well developed or robustly supported. For example, one HCA we spoke with said they had never had an appraisal, did not have a good knowledge of safeguarding and said they did not know how to submit an incident report. They said they had not received training on the electronic incident reporting system and would not know what to do if they were involved in an incident.
- We observed nurse handovers on the AICU and the HDU. Staff demonstrated a good knowledge of each patient's needs, including of their mental capacity and social needs. Where an infusion had been changed overnight, the nurse explained the reasons for this and explained any additional safety checks that were needed as a result. Staff conducted a manual check of the infusion devices at each handover and made sure these matched the prescription on the electronic records system. There was a clear focus on safety and patient comfort and staff demonstrated compassion and understanding to their patients.

- The hospital provided an 'orientation passport' for agency nurses to complete prior to starting work in the department. This made sure nurses understood the location of equipment and medicines and could work effectively and safely.

## Medical staffing

- Eight consultants led medical care on the HDU. One consultant was an intensivist, three were anaesthetists and cardiology, surgery and respiratory were represented. There was one vacant consultant post. Consultants in the HDU were available seven days a week from 8am to 6pm. Out of hours a registrar was always available in the unit and a consultant on call was able to attend within 30 minutes.
- An ECMO-trained consultant was available on call 24-hours, seven days a week.
- The AICU did not always meet the requirements of the Faculty of Intensive Care Medicine (FICM). This was because patients were not always assessed by a consultant intensivist within 12 hours of admission and did not always have a treatment plan discussed with a consultant intensivist in intensive care medicine. This occurred when patients were managed by a surgical consultant for the first 48 hours of their admission. This also meant not all patients were seen daily by a consultant intensivist in intensive care medicine.
- Medical care in AICU was led by consultant intensivists who were supported by registrars and senior house officers. Nine consultants had recently left the unit, which had caused significant challenge to the remaining team. The clinical director had established a cross-site rota for consultants from the Harefield ICU to work at the Royal Brompton site as an interim measure and a team of new consultants had been recruited. This had not resulted in any gaps in care or uncovered shifts. Critical care services met the FICM requirement of at least one consultant to every 18 patients. Consultant cover was from 8am to 9pm seven days a week. Out of hours a consultant intensivist was available on-call within 30 minutes.
- Consultant-led ward rounds on the AICU took place three times daily and were supplemented by three daily medical handovers. On the HDU, a consultant led a twice-daily ward round and medical handovers took

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place twice daily. Ward rounds included trainee doctors, the nurse in charge and the individual nurse for each patient. This did not always include patients who were in the AICU but still under the care of surgery staff.

- Junior doctors worked on a rotation system through critical care. They were expected to attend a number of ward rounds and multidisciplinary meetings. This represented good practice but meant they had little time to work one-to-one with patients. In addition, not all junior doctors were expected to undertake an AICU training course and there was inconsistent oversight of their teaching, learning and supervision in this unit.
- A team of nine senior house officers provided support to junior doctors on HDU and were available from 8am to 5pm, seven days a week.
- Although the AICU and HDU were independent of each other, some consultants worked between both units. After the ward round, the consultant from each unit led a team huddle with junior doctors and the nurses in charge to discuss specific patients. During our observation there was little involvement of junior doctors. For example, one individual used their mobile phone throughout the huddle without participating and without being challenged. Junior doctors on AICU told us they lacked supervision and support and that working on the unit was often very challenging.
- Junior doctors on HDU told us they felt well supported and described their training and supervision as “excellent.”
- A FICM tutor had recently been appointed to improve the supervision of junior doctors. Clinical educators assisted this member of staff by participating in junior doctor inductions to highlight the different roles and responsibilities of the nursing team.
- A surgical rota was in place to support veno-arterial ECMO patient admissions, which were infrequent.

## Major incident awareness and training

- A major incident and evacuation plan was in place that included clear roles and lines of responsibility for staff. This included a fire warden on each shift and radios with an independent power supply in the event telephones failed. All of the staff we spoke with were confident in their understanding of evacuation procedures. A simulated evacuation had taken place in the 12 months

prior to our inspection that included assessed role plays of how staff behaved in a smoke-filled environment and how they managed ‘patients’ in beds who needed to be evacuated. The exercise included consideration of ECMO patients who were more challenging to move. Learning from this exercise was used to develop safety and emergency training.

- In an emergency, staff wore highly visible badges that indicated their role, such as nurse in charge or emergency coordinator. This helped staff in the area understand what each person was responsible for.
- Every bed in the AICU included an evacuation sheet that staff could use to quickly move people out of the unit in the event of an emergency.
- A new fire and evacuation risk assessment was in place in the AICU that took account of the closure of part of the unit. Staff could still use this as an evacuation route if needed and there was no impact on patient safety. Senior nurses told us all staff had been briefed on this. However, five members of staff we spoke with said they did not know if they could use the closed area as a means of escape. One member of staff said they definitely would not use this as an evacuation route because they could not see into the unit for hazards without opening the doors and breaking the infection control containment seal.

## Are critical care services effective?

Good



### We rated critical care services at the Royal Brompton Hospital as good for effective because:

- Staff gave care and treatment in line with national and international guidance and using established tools and systems. This included guidance from the National Institute of Health and Care Excellence, the UK specialist Rehabilitation Outcomes Collaborative and the Match Michigan Study.
- Critical care services had implemented the Faculty of Pain Medicine’s Core Standards for Pain Management (2015) and there was evidence of consistent support to monitor and reduce patient’s pain.

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- Two dieticians were dedicated to critical care and provided continuous monitoring and support. Patients spoke highly of the service offered by dieticians.
- The survival rate of patients who were treated with extracorporeal membrane oxygenation (ECMO) was higher than the international average measured by the Extracorporeal Life Support Organization.
- The number of nurses with a post-registration qualification in intensive care medicine exceeded the minimum requirement of the Royal College of Nursing.
- A team of clinical educators were responsible for nurse education, teaching and learning. This team was embedded in both units and had a clear focus on nurse retention and development. This included providing nurses with leadership pathways and opportunities to develop their own professional interests.
- Some nurses worked within distinct quality groups that aimed to standardise practice and treatment for patients and improve the work of the units.
- A multidisciplinary team had input into patient care and treatment and worked well together to improve outcomes. This included physiotherapists, dieticians, occupational therapists, pharmacists and microbiologists.

## However:

- New consultants in the adult intensive care unit (AICU) did not always receive an adequate induction in the units. This meant they were not always aware of the local procedures and policies in place and this caused delay to treatment and conflict within the team. After our inspection the trust provided details of the induction all consultants received and it was therefore unclear why staff we spoke with were unaware of this.
- There was room for improvement in cross-site working and learning in ECMO treatment between the trust's two critical care sites.
- Junior doctors in AICU were not always aware of the support available for learning, supervision and development. This was due to the departure of a number of consultants and we were told this was due to change imminently. In addition, the trust provided information regarding the education and pastoral support in place.

## Evidence-based care and treatment

- Patients retrieved from other hospitals for extracorporeal membrane oxygenation (ECMO) treatment in the adult intensive care unit (AICU) were transferred using an established transfer protocol that followed the latest best practice guidance. In 2014/15, 150 patients had been transferred with no mortalities.
- The physical therapies team was funded to provide specialist rehabilitation services for critical care patients and benchmarked the standards of their work by collecting data for the UK specialist Rehabilitation Outcomes Collaborative.
- Staff assessed patients on admission and then at regular intervals for delirium using the confusion assessment method for intensive care units (CAM-ICU) and the Richmond Agitation and Sedation Scale (RASS). Clinical educators trained staff on the use of CAM-ICU in critical care services and encouraged them to use non-pharmacological intervention. For example, when a patient with hypoxia attacked a member of staff and behaved violently, staff kept them safe and waited for them to exhaust themselves and fall asleep before treating them. This meant the patient and staff were not harmed and reduced the need for sedation.
- Clinical educators from the high dependency unit (HDU) and AICU formed a joint-working tracheostomy safety group. Together they established standardised working procedures, including a standard operating procedure for tracheostomy care in patient bed spaces. The introduced new cleaning guidelines through training sessions that enabled staff to improve infection control practices.
- Staff adhered to the best practice guidelines of the Match Michigan Study in the use of central venous catheter bundles to minimise the risks of infection.
- Nurses had completed a project to improve end of life care on the unit by identifying gaps in training and knowledge and ensuring policies and guidance were consistent. As a result of this, staff implemented NICE clinical guidance 31, care of the dying adult in the last days of life. This helped them to benchmark their practice against national guidance.

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- A project was underway in respiratory weaning and aimed to make sure nurses supported patients effectively and according to best practice guidance.
- There was a lack of evidence of engagement with junior doctors in clinical audits. Doctors we spoke with said they were not supported to complete audit programmes and had limited opportunity to set these up themselves.
- The critical care team worked with physiotherapists to meet rehabilitation needs in line with NICE clinical guidance 83. Physiotherapists audited compliance against this guidance. Recent results highlighted a need for improved communication between teams when a patient was stepped down from level three care. The audit team also established more robust short and long-term goal setting for patients with a rehabilitation plan. Another physiotherapist was setting up an audit programme to assess the outcomes of the rehabilitation programme.
- Regular audits included ECMO blood transfusion and ventilator care bundles although it was not clear how the results had impacted or improved care.

## Pain relief

- Critical care services had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and we saw this was followed through patient records and observations.
- A pain management sister was available on site and provided on-demand support for critical care staff.
- A specialist pain team worked in surgery and pre-assessed elective admissions to critical care to help plan their pain management. This team was also available on-call and provided advice during multidisciplinary meetings and ward rounds when needed.

## Nutrition and hydration

- Dieticians recorded nutritional reviews in patient's electronic records. This included checks of malnutrition, waterlow scores and the maintenance of nasogastric feeding tubes. The use of the malnutrition universal screening tool was standardised in critical care.

- Critical care units had snacks and drinks available for patients and relatives 24-hours, seven days a week. Units had a stock of sandwiches, yoghurts and nutritious drinks on site and could order hot meals from the catering department.

## Patient outcomes

- The service had not previously contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could not be benchmarked against critical care units nationwide. The unit used data from the northwest London critical care network to assess effectiveness and patient outcomes. The senior clinical team had begun to submit data to ICNARC and planned to use this in the future.
- The senior sister in HDU had developed a patient information board using a visual colour-coded system that enabled staff to quickly find specific information and to note warnings. For example, patients with similar-sounding names were highlighted, as were those ready to be discharged. The patient safety nursing quality group had completed work to improve the accuracy of patient identification, including reminding staff to make sure they spelled names correctly. Nurse leads for medication, airways, scribes and circulation were also listed on this board. This meant bedside nurses could rapidly get support with specific elements of patient care when needed.
- The survival rate for patients who received ECMO in 2014/15 was 69%, which was better than the Extracorporeal Life Support Organization international average of 50%.
- Staff described a reduction in continuity of care in the AICU due to high turnovers of staff. They said that new consultants and nurses had very different styles of working than they were used to and it was difficult to maintain working practices because of the lack of oversight and supervision of new medical staff.
- Organ donation resources were available and the deputy matron on AICU acted as the organ donation link for critical care services.
- Nurses were able to perform extubation on patients who had undergone simple cardiac procedures. Clinical

# Critical care

educators managed staff skills in this area and nurses who were trained to perform this procedure were rotated on shifts through recovery to enable them to maintain their skills.

- Clinical educators had included ILS and ALS training in job planning for senior staff nurses and with new funding there was scope for 75% of staff to have ILS or ALS training. Life support training for patients after a cardiac arrest was a new training course offered to critical care nurses. Three members of staff said they felt life support training could be improved. For example, two nurses said they didn't feel BLS training was advanced enough for their work in critical care. Another nurse said their ALS training had been cancelled on several occasions and they did not feel it was a priority of the unit. The trust told us there was no record of any ALS training sessions being cancelled.

## Competent staff

- Newly appointed consultants were not always given adequate briefing or induction into critical care policies and standard operating procedures. For example, the AICU had introduced bladder scanning as an alternative to bladder washing. However, new consultants had not been aware of this and senior nurses told us they had needed to escalate concerns about differences in practice. Clinical educators acted as links between new consultants and nursing staff to help standardise practice. However, some clinical staff said they worried when some doctors were vocal about their feelings about the competency of colleagues. After our inspection the trust told us bladder scanning had not been introduced and that they had no evidence of nurses escalating concerns. In addition, evidence was provided that consultants were provided with a standard induction and a mentor for their first two years in the trust. It was not clear why we received different information from members of staff and the trust.
- A team of three clinical educators on the HDU and two clinical educators on the AICU led learning and teaching and had responsibility for meeting staff educational needs.
- Clinical educators on the HDU offered a daily 20 minute bedside 'micro' teaching session. Any clinical member of staff could attend. Topics were chosen based on care pathways and bundles specific to the HDU such as tracheostomy care and balloon pumps. Micro teaching included practical safety competency checks. This team also offered a twice-yearly critical care course for new nurses or those on rotation from a medical ward. This included topics such as caring for deteriorating patients.
- Band six nurses were supported by educators to develop in a clinical facilitator role. This was part of a leadership development pathway that enabled them to work with new nurses in a supervisory role in the clinical environment.
- Clinical educators maintained competency checks of staff in the use of equipment, including practical assessments and training to respond to equipment failure. For example, clinical educators set up haemofiltration pumps and assessed staff in their use so that practical skills were assessed.
- Staff had access to the trust's Simulated Interprofessional Team Training Programme (SPRINT) that used a simulation mannequin and training suite. Clinical educators and three simulation facilitators used this facility to conduct real-time assessed scenarios using a full complement of staff including an on-call consultant, specialist registrar, junior doctors and nursing team. This was an essential element of the provision of clinical training and included simulations of high-risk scenarios including altered airways and the escalation of airway management. There was evidence of significant learning from simulation training, including the need for staff to know where to find emergency equipment and supplies they might need rarely.
- Although all staff were included in learning outcomes from simulation, some staff told us they were disappointed they were not included in simulation exercises. For example, some nurses said they missed out on training because the simulation exercises were offered only to band six grades and above.
- Clinical staff trained to care for ECMO patients using the simulation suite and a programme was underway to make sure all nurses were trained in this.
- High-fidelity simulation training had been suspended due to the loss of the consultant lead. With a new intake of consultants, clinical educators planned to re-start this programme.



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- Clinical educators were supernumerary to the rostered nurse staff establishment. This meant they could provide responsive, on-demand learning and teaching to staff.
  - Staff recruited from outside of the UK had access to English language proficiency training and preceptorship.
  - HDU staff had undertaken human factors training to support effective communication. Staff told us this had improved communication during difficult or time-critical situations and helped them to establish stronger working relationships with new staff.
  - Critical care staff undertook safe blood training every two years that included a practical assessment of blood competency. This also helped to make sure staff responded to patient risks and catastrophic blood loss quickly and effectively.
  - Some junior doctors told us they had not been consistently or adequately supported with teaching, learning and supervision. We spoke with a consultant who told us this was part of the outcome from the departure of nine consultants and a new programme of education had been implemented. Junior doctors were offered special interest days to support them with professional development in their areas of interest. After our inspection the trust provided details of the support offered to junior doctors. This included an extra faculty tutor, confidential weekly meetings with the trust director of medical education, reassignment of medical supervision and pastoral support.
  - In AICU, 65% of nurses had a post-registration qualification in intensive care. This was better than the minimum standard required by the Royal College of Nursing.
- between staff meant there was a lack of focus and a risk that junior members of staff could miss instructions relating to medicines and clinical findings. Staff did not provide a summary at the end of each patient reviewed.

- A weekly multidisciplinary team meeting took place for all critical care patients. This was a detailed and substantive review that included input from a psychologist, physiotherapist, the palliative care team, a chaplain, the HDU and AICU consultants and staff from each of the physical therapies.
- A microbiologist conducted a daily ward round and an x-ray meeting was also held daily.
- Staff worked with a range of other professionals depending on individual patient need. For example, staff contacted GPs and clinical psychologists to support the rehabilitation process after discharge from the unit. Staff had also established links with specialists outside the hospital who could provide support. This included palliative care consultants, diabetic specialist nurses and psychiatric liaison nurses.
- Clinical educators in the HDU and AICU had planned opportunities for joint learning exercises between their teams, including simulation exercises. This was part of a plan to improve patient outcomes by providing more frequent opportunities for staff to work together. .
- A critical care therapy lead managed a multidisciplinary team of six physiotherapists, two occupational therapists, two dieticians and two speech and language therapists. This meant the multidisciplinary therapy team worked consistently with clinicians and long-term patients. A multidisciplinary team from nine specialties provided care and treatment to ECMO patients in AICU. This included staff from surgery, perfusion, respiratory medicine, pharmacy and clinical engineering.
- There was limited evidence of multidisciplinary working between ECMO teams at the Royal Brompton site and the trust's Harefield site. An attempt to establish a referral management process for the transfer of patients and/or staff between sites based on clinical need had stalled in May 2015. However, new working arrangements between consultants at both hospital sites as a result of the departure of nine consultants had resulted in an improved relationship. This meant clinical staff with ECMO training at both sites established more frequent communication.

## Multidisciplinary working

- We observed a ward round in AICU. Although this was well attended by members of the medical and nursing teams, the coordination of the ward round meant there was a risk important information would not be communicated with the most appropriate person. For example, during one handover two bedside nurses were on their break and so instructions from the consultant were passed to other nurses who had not been caring for the patients. In addition, individual conversations



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- Nurses from the HDU worked within five distinct nursing quality groups. The groups worked to standardise care and share knowledge between teams and were supported by nurses who rotated between the HDU and wards. The five quality areas were communication; the admissions process; the discharge process; patient safety and the fundamentals of nursing care. We spoke with nurses who worked in the groups and found attention to detail and a focus on improving patient outcomes. For example, the communication group had worked on empowering ward staff to escalate concerns about deteriorating patients. The fundamentals of nursing care group worked to improve staff skills in skin preparation and nutrition and the patient safety group worked with staff to reduce falls risks and improve the accuracy of documentation.
- There were no formal systems in place to record communication between some multidisciplinary teams. For instance, when an infectious patient had been taken for x-rays, the x-ray technician had not been advised they needed to disinfect the equipment afterwards. This was because word of mouth messages were not passed on. After our inspection the trust told us an electronic system was in place that staff should use to request x-rays. Infection risks could be highlighted in this system and the trust told us they would increase awareness of this amongst staff.

## Seven-day services

- Physiotherapists conducted daily visits to critical care and occupational therapists, dieticians and speech and language therapists were available routinely Monday to Friday. Out of hours, staff had access to an on-call service.
- Physiotherapists provided a 20-minute response time to calls from clinical staff on a 24-hour, seven days a week basis.
- Consultant and junior doctor cover was provided 24-hours, seven days a week.

## Access to information

- Staff had access to medical history and records from other areas of the hospital and other providers through

the electronic system. This information could be viewed alongside current observations and assessments to help clinical staff in their treatment plans and decision-making.

- Discharge plans and letters could be generated from the electronic system which ensured GPs and community health providers received timely and up to date treatment summaries.
- Staff at both the Royal Brompton and Harefield sites had access to the same information systems, including for ECMO patients. This meant patient transfers could be completed monitored by clinicians at both sites.

## Consent and Mental Capacity Act

- The majority of patients in critical care were planned in advance as elective admissions. This meant consent was obtained and documented in advance of admission.
- Doctors completed mental capacity assessments when they felt a person's judgement or ability to understand was diminished, although trainees could not recall any formal training on the subject. A documented record of capacity was not always recorded in patient notes. Nurses had some training mental capacity and doctors were responsible for completing assessments.
- All clinical staff received training in the Deprivation of Liberty Safeguards (DoLS) and how this applied in the critical care environment. Nurses were able to contribute to best interests discussions and doctors made formal referrals to the local authority for an authorisation.
- The Mental Capacity Act (MCA) (2005) was not part of the trust's mandatory training programme but staff we spoke said it was discussed in their safeguarding training and they had a good understanding of it. Critical care staff had been involved in the development of trust guidelines on the use of DoLS and this was included with the MCA in the context of consent training.

# Critical care

## Are critical care services caring?

Good



### We rated critical care services at the Royal Brompton Hospital as good for caring because:

- Staff offered compassionate and individualised care in all of our observations. This included reducing anxiety by spending time talking and developing written communication to help a patient who was deaf.
- The AICU conducted a survey of patients on relatives and used feedback to improve the service. Critical care staff organised an annual patient day that enabled former patients and relatives to attend the hospital and discuss their experiences.
- All of the patients and relatives we spoke with told us nurses, doctors and the multidisciplinary team they had met had been friendly and approachable.
- Staff demonstrated good knowledge of their patients. For example, during a ward round a consultant went out of their way to address one patient's anxiety and worry at their planned move to another area of the hospital. Nurses worked with the same patients on each shift where possible to ensure consistency of care.
- Staff supported relatives practically and emotionally. For example, staff got to know relatives and spent time with them to explain procedures and treatment and to reassure them where possible.
- Emotional support services for patients and relatives included bereavement, counselling, psychology and chaplaincy services.

### However:

- Staff did not always speak to each other in front of patients in English, which some staff told us was inappropriate and caused discomfort to patients, relatives and other staff.
- There was inconsistent documentation of conversations with relatives and decision-making discussions.

### Compassionate care

- Critical care services did not participate in the Friends and Family Test (FFT) or an equivalent. A senior nurse in

the high dependency unit (HDU) was developing plans to introduce a feedback system from patients that would use text messages after they were discharged. The adult intensive care unit (AICU) had developed their own survey and used this to obtain feedback from relatives and feedback.

- On the AICU, recent feedback from patients was displayed on an information board at the entrance to the unit. This included details of positive feedback about staff.
- Staff always provided patients with the opportunity to discuss incidents where they had behaved violently due to delirium. This helped patients to understand their behaviour and why it had occurred. This was a compassionate approach to patient support because it helped to reduce feelings of guilt and confusion.
- Staff we spoke with said they felt patients were always treated compassionately. Some members of staff felt the hospital should make it a requirement for staff to speak English when talking to each other at patients' bedsides. They said senior staff were reluctant to enforce this and when some staff asked colleagues to speak English in front of patients they were often ignored. This could reduce the caring approach felt by patients.
- All of the patients we spoke with told us they were very happy with the care provided. They said nurses and doctors were always visible and easy to speak with. One patient said they had received particularly good care from a dietician who helped them understand how long it would be until they could eat again.

### Understanding and involvement of patients and those close to them

- Consultants demonstrated a detailed knowledge of each patient. For example, during a team huddle, a consultant spent time discussing the anxieties of a patient who was planned to be transferred from AICU to HDU. They knew the patient well, including their social situation, and made it clear to other staff what was needed to understand the patient's state of mind. This included involving them in the transfer process and inviting them to meet the nurse in charge on the HDU so that a familiar face would be waiting for them when they arrived.

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- Clinical staff ensured patients with communication needs were involved in their treatment and care. For example, where a patient had hearing loss, staff communicated using notes and only proceeded when they were sure the patient had understood the message.
- Staff demonstrated a clear focus on getting to know relatives who came to the unit. This included understanding their worries and fears, involving them where appropriate in decision-making and making sure they looked after their own wellbeing.
- Clinical staff and members of the multidisciplinary care team documented their discussions with relatives in most cases. There was room for improvement in the consistency of how visits and conversations were recorded. For example, some conversations were recorded in the electronic system, some in surgical paper notes and some were not recorded at all.
- Multidisciplinary critical care staff organised an annual patient day and invited former patients and relatives to attend. This provided visitors with an opportunity to speak with staff, learn about the critical care environment and give feedback on their experiences to staff. Attendees were asked to give feedback and indicated that the opportunity to meet with staff and share their experiences were valuable elements of the experience.

## Emotional support

- Staff could refer patients and relatives to a counselling and bereavement service both during a hospital admission and afterwards, as part of the follow-up service.
- A chaplain visited every pre-operative patient if they wished and this contact was maintained once patients were admitted to critical care. The chaplaincy team was multi-faith and operated 24-hours, seven days a week.
- The palliative care team recorded meetings, notes and observations in electronic patient records. This included details of emotional support provided.
- Staff from multidisciplinary teams worked closely together when it was in the best interests of patients. For example, one patient had a low mood and was at risk of depression from an extended critical care stay. To

ensure they maintained their rehabilitation programme, a physiotherapist arranged their daily sessions with a psychologist to provide mental health support to the patient.

## Are critical care services responsive?

Good



### We rated critical care services at the Royal Brompton Hospital as good for responsive because:

- Clinical staff offered a critical care follow up service. This helped patients and their relatives to understand their stay and supported them with rehabilitation. This service could be offered remotely by telephone if needed.
- Staff used patient diaries to document important steps in recovery. Staff and relatives contributed to these and they were used as part of the follow-up rehabilitation service.
- Support was available for patients with dementia, a learning disability or other needs relating to communication. Translators were available and Arabic translators were available on site at most times.
- Printed information for relatives included photographs of critical care equipment with a description of what they were for and how they were used in treatment.
- A weekly multidisciplinary meeting took place for 'long stay' patients. This helped to ensure on-going treatment was appropriate and met the needs of patients.
- There was a clear drive from clinical teams to ensure access and flow was supported by robust discharge planning and the minimisation of unnecessary delays. This included nurse quality teams dedicated to reviewing admissions and discharges to streamline processes.
- A complaints procedure was in place and readily available to patients and relatives. There was evidence of learning from complaints.

### However:

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- There were limited facilities for relatives. For example, a refurbished waiting room was available near the adult intensive care unit but this had no facilities for drinks or snacks.
- The trust had not historically contributed to the intensive care national audit and research centre (ICNARC) programme, which meant there was limited evidence how the unit compared nationally to benchmark data for access and flow.

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

- A critical care follow-up service was offered twice monthly by a locum consultant and two adult intensive care unit (AICU) nurses. This service helped patients to understand their stay in critical care and they were able to meet the clinical team who had cared for them. The process helped to reduce the impact of post-traumatic stress and enabled patients to reflect on their memories in a supported and safe environment. Staff offered telephone support for patients who lived outside of the UK or who would find it difficult to travel to London.
- Staff offered patients who returned in the outpatients department the opportunity to return to the unit to talk to staff they met during their treatment.
- Consultants worked with the northwest London critical care network and the pan-London critical care networks steering group to plan and deliver services that took into account demand on services and learning from other critical care units.
- Critical care patients had access to the respiratory medicine weaning unit, which was also able to support patients after discharge in the community. Two AICU nurses were named link staff for weaning protocols and supported colleagues in their use.

## Meeting people's individual needs

- Patients had an information board at their bedside that listed their consultant and nurse. This was not used consistently and on one day of our inspections, three of the nine patients on AICU did not have a named consultant listed on their bedside board.
- A consultant demonstrated an excellent knowledge of one patient's communication needs following an operation. For example, they wrote clear and simple

messages to a patient with hearing loss and checked for an acknowledgement of their understanding before continuing. The consultant had adapted this process to meet the needs of the patient once they established an understanding between them.

- Staff demonstrated an understanding of the needs of patients beyond immediate clinical need in critical care. This included contact with specialists regarding a patient's alcohol and nicotine withdrawal.
- Patients had access to a range of foods including soft options, vegetarian, gluten free, healthy heart options, halal meat and kosher food.
- When patients began to recover, clinical staff gave them control over the visiting times of their visitors. This enabled patients to plan visits around how they were feeling and the speed of their recovery.
- AICU staff used patient diaries that followed a gold standard protocol. This meant the diaries were inclusive of the patient, staff and relatives, were completed daily and included photos where appropriate. A member of staff gave the diary to the patient as part of a debrief session after discharge. This included a consultant, nurse and a psychiatric liaison nurse if needed. A project had been completed that used electronic tablets for patient diaries. This included daily entries and photos from staff, relatives and the patient where possible. Staff had stopped the project temporarily while they reviewed it for effectiveness.
- A vulnerable adults lead was able to provide support to staff when caring for patients with a learning disability. Staff also had access to a visual communication pack that included pictures and large-print text to help them interact with patients who could not communicate verbally. Staff also told us the occupational health team were able to help them develop communication strategies with patients with a learning disability.
- Where patients were admitted who did not speak English, staff established their first language and then communicated with all trust staff using a secure e-mail service. This helped to identify any staff that would be able to act as a translator. The hospital had access to Arabic translators on call through the bleep system.
- Staff were able to plan ahead to support elective admission patients with communication needs,

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including through the use of British Sign Language (BSL) interpreters. There was documented evidence the patient had been reviewed by a multidisciplinary team, including a MacMillan nurse and the same staff nurse had worked with the patient each day to improve continuity of care.

- Visitors and relatives to AICU had the use of a quiet room nearby. This included comfortable seating but there were no refreshment facilities. Staff had provided information on local amenities including where they could eat and sleep. Information on the unit and the types of treatment patients might receive was also included. Photographs of critical care equipment were printed alongside an explanation of what the equipment was for. Visitors and relatives to HDU had access to a quiet room shared with medical wards. Water and hot drinks were available in a pantry on the unit. Neither unit had overnight accommodation or dedicated space for difficult conversations. However, relatives could stay overnight in accommodation provided by the hospital off the units and staff said there was always an office or side room they could use for private discussions.
- Relatives were given food vouchers to use in the hospital's restaurant and coffee shop. Staff encouraged people to use this scheme to give them a break from being inside the unit and to make sure they managed their own wellbeing while caring for a sick relative.
- Staff completed a weekly multidisciplinary 'long stay' meeting for patients who had been in critical care for more than seven days.
- There was room for improvement in how clinical staff engaged with external professionals for the benefit of patients. For example, a BSL interpreter booked through an external agency caused concern and conflict with the nurse and medical teams. There was no framework within which this professional understood their role and the unit did not have guidelines for visiting professionals or support staff.

## Access and flow

- Between July 2015 and July 2016, the AICU treated 4308 patients and operated at 84% of capacity. In the same period the HDU treated 2306 patients and operated at 82% capacity.

- In 2014/15, the AICU redirected 40% of extracorporeal membrane oxygenation (ECMO) referrals on the NHS England pathway because of a lack of capacity.
- There were limited data available from the trust about bed movements and delayed discharges. The most recent data available were for the period April 2014 to March 2015 and indicated 452 delayed discharges took place. Critical care discharge delays are measured by the Intensive Care Society as less than four hours, between four hours and 24 hours and over 24 hours. However, the trust had not recorded this information.
- The critical care unit had not historically contributed to the intensive care national audit and research centre (ICNARC) programme. This meant we were unable to compare the number of delayed discharges with other comparable units nationwide. We requested data on the most recent North West London critical care network peer review to allow us to compare the number of delayed discharges with similar units nationwide but the trust were unable to provide us with this data.
- The HDU nurse in charge conducted a morning board round every day before the nurse and medical handovers. This process helped to identify patients who were ready for discharge and those who would be admitted to the unit from ICU recovery. The early identification of patients ready for discharge helped to negotiate access and flow with bed managers and meant delays to admissions were reduced.
- Two nursing quality groups contributed to improved access and flow in critical care; one focused on the admissions process and the other on the discharge process. The two groups worked closely with the medical team and senior staff to reduce delays through the early identification of deteriorating patients and the identification of patients ready for discharge two days in advance.

## Learning from complaints and concerns

- Critical care services adhered to the trust's complaints procedure. This was readily available in relatives' waiting areas and in published information in the unit. In the twelve months prior to our inspection, AICU had received two formal complaints. There was evidence of learning from the outcome of complaints investigations.



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For example, one complaint was caused by a relative receiving inaccurate information. As a result staff were trained in providing accurate and timely information to appropriate people.

## Are critical care services well-led?

Requires improvement



**We rated critical care services at the Royal Brompton Hospital as requires improvement for well led because:**

- During our inspection a total of 37 staff members asked to speak with us on the condition of anonymity. This included staff from a varied range of roles and levels of seniority. Each person wanted to raise concerns about leadership and management in the adult intensive care unit (AICU), which they said affected their ability to do their job. A significant number of staff in this group also raised concerns about infection control practices in the AICU and how these were being managed.
- There was broad and inconsistent understanding of the vision and strategy of the service across all grades of staff. Senior staff had their own future strategies in place but more junior staff did not know about these. The adult intensive care unit (AICU) had been affected by the departure of nine consultants and a number of staff said this meant their only vision for the future was to find a way to cope. There had been no communication to the junior medical staff about how the consultant vacancies were to be filled in the future.
- From our discussions with staff, clinical governance processes did not include scope for learning and working together between critical units, including between the AICU, high dependency unit (HDU) and the HDU on Victoria ward. After our inspection the trust provided information on the shared learning opportunities available, including through a shared leadership structure of AICU and HDU and the oversight of a cross-site critical care director.
- Risk registers were used to track and monitor risks such as the environment and staff shortages. Senior staff we spoke with did not always have knowledge of the current status of risks or how they were being managed.

- Communication between staff and teams was inconsistent. This included between consultants in different departments, in the supervisory process for junior doctors and from senior staff when establishing new project roles for nurses.
- Risk management in relation to staffing was not appropriately managed in the AICU and it was not clear whether the senior team listened to or engaged with staff appropriately when they raised concerns and problems.
- Thirteen members of AICU staff told us they felt there was poor communication from some of the senior team. This included a reliance on communication by e-mail, lack of support during a period of unpredictable change and the arbitrary change of working patterns and conditions without consultation. The minutes of senior staff meetings did not indicate there was a robust understanding of the feelings of the nursing team.
- Concerns about clinical risks escalated by nurses in the AICU were not always addressed or acted upon in a timely fashion, such as in relation to infection control processes and the provision of trust policies to new consultants. This contributed to poor working relationships and increased risk in practice.
- The critical care unit had only recently started contributing to the intensive care national audit and research centre (ICNARC) programme, which allows comparing clinical indicators with other hospitals. This meant that they were unable to use the ICNARC data to monitor patients' outcomes and the effectiveness of the service.

### However:

- The clinical director had introduced cross-site clinical meetings to improve joint working practices.
- There was a consistent focus on staff specialisation and training. In the HDU, staff were supported to develop and progress their practice and career. Some senior staff supported their teams through the approval of sabbaticals, study leave and research projects. Nurses were encouraged to be involved in quality improvement projects such as in end of life care.
- Staff in the AICU had been offered group support sessions with a psychologist to help address low morale and rising rates of sickness absence and attrition.



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- Staff in HDU felt supported in their role and said they were respected and praised by the senior team for good work.
- Changes to the service had been made through public engagement, including a new nurse uniform in HDU and improved waiting areas.
- Team meetings in the HDU contributed to positive working practices and relationships between staff at all levels.

## Leadership of service

- Critical care staff were recruited internationally and some senior staff recognised the benefits of a flexible approach to working hours and annual leave to allow them to travel to see relatives. Managers in other hospital departments said they found this approach had resulted in better performance from staff. This policy had changed in the AICU and staff told us there had been restrictions imposed on their working patterns and time off without due process or consultation. This had resulted in an increased sickness rate and turnover rate of nurses. The trust recognised this and told us the leadership approach to staffing ensured fairness and balance in line with the needs of the service.
- The nurse vacancy rate on HDU was 5.2% and on AICU was 6.8%. We spoke with staff from human resources about this. The department contacted staff before they left and tracked their reasons to identify any themes or problems. The reasons staff had given for leaving critical care in 2016 did not indicate any consistent problems.
- A deputy matron worked clinically and supported the AICU team. All of the staff we spoke with told us this individual was highly respected and they felt supported when the deputy matron was on shift. One member of staff said, “[Deputy matron] has been very present during this challenging time.” Another member of staff said, “The deputy matron is great at keeping us up to date. She acknowledges our concerns and has shown a lot of empathy to us in the last few months.”
- Some clinical staff said they felt supported by the heart division manager. One member of staff said, “We’ve got the back-up we need from [manager]. He’s visible and doesn’t judge and is a great listener.” Where staff could not be released from clinical duties for hospital forums, they told us the manager walked around his units and spoke with staff about discussions that had taken place. Staff told us they felt a new leadership team was beneficial to their work. One person said, “The senior team are good mentors for managers – they help us understand what they do so we know ourselves when it’s time to move up.”
- However, other staff told us they were concerned about the failure of senior staff to act on documented risks to patient safety. This included the risks of infection control from treating patients in AICU side rooms that were not equipped for negative pressure air flow. Clinicians told us they had raised this on numerous occasions at management meetings but felt they were “not taken seriously.”
- Some staff described the senior leadership team in the division as “fair, focused on raising morale and without favouritism.” However, other staff described significant communication problems and a lack of trust and confidence in the senior team.
- The divisional nurse manager (DNM) had an open door policy for staff. This meant staff in any role could speak with her confidentially and without an appointment. All of the staff we spoke with were aware of this and several said they had approached the nurse manager for support with the challenges faced on AICU. Five members of staff told us a number of colleagues had approached the DNM collectively to discuss the changes imposed on working times and practices by a new senior member of the team.
- Leadership in the AICU had changed significantly in the previous 12 months. Thirteen staff spoke with us about this and raised a number of concerns about the way they were managed and communicated with. One member of staff said they wanted more open communication with the senior team and felt that the preferred method of e-mail created a barrier. They also said they felt staff were not routinely consulted or considered in changes in practice or policy. We looked at the minutes of meetings between senior staff in the AICU. There was evidence senior staff were aware of deteriorating morale in the unit but there was limited evidence strategies to address this were identified and considered. A priority was placed on discipline and performance management and there was little evidence the senior team had engaged effectively with staff.
- As part of a new leadership approach, junior doctors had been told they were not allowed to eat or drink on the unit. This rule had been imposed without discussion and junior doctors told us they felt it was unnecessarily

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restrictive as they needed access to water throughout their shift to remain hydrated. Although this had been escalated to the clinical director, junior doctors told us they had not received a reply.

## Vision and strategy for this service

- The senior leadership team had not communicated consistently with staff about the strategy and future plans for the service and this had affected how staff felt about working there. For example, one member of staff said a plan to open additional extracorporeal membrane oxygenation (ECMO) beds in 2016 had been suspended but they did not know why. They said, “Suddenly the meetings stopped, talks stopped. We’ve had no communication about what’s happening.” Another person said they were worried about the loss of a number of experienced consultants from the adult intensive care unit (AICU). They felt there had been no communication from the senior team and as a result morale amongst some clinical staff was very low. Nine members of staff spoke with us about this. They said they were concerned about the future of the unit and about their professional development. However, the number of consultants who were trained in ECMO treatment had significantly decreased following the departure of a number of them. As there were fewer staff that could care for patients receiving ECMO treatment, the development of the strategy had to be paused to consider future recruitment.
- Nurses we spoke with in the AICU were uncertain about the vision and strategy for the future and acknowledged the importance of stabilising the team after the significant changes they had experienced. One nurse said, “We need to know what sort of unit we’ll be, what sort of patients we’ll take and where we go to next.” Staff told us they had not been updated about changes in the unit on team days. One member of staff said, “I’m really worried about so many consultants leaving. I asked one of the [consultants] still here about it on a team day and they didn’t know what would happen next. So our vision has to be to just keep the team together.”
- Plans to develop ECMO services at the Royal Brompton site had been affected by a lack of effective engagement with ECMO staff at the trust’s Harefield site. Clinical staff

told us a management committee had approved in principle the development of ECMO services but there was no implementation plan, timeline or consistent communication between teams.

- The high dependency unit (HDU) matron and senior sister had a clear view of staff development and specialisation. Continuing to provide specialist training to nurses as a strategy for professional development and the reduction of turnover was a core element of their future plans. They told us a focus on making small changes that have a big impact helped them to share learning across the trust and to manage service development at a pace staff could work well in.
- Clinical educators in AICU planned to introduce a research nurse post to support clinical development and ECMO treatment.
- The clinical director planned to introduce more opportunities for nurses and doctors to train together and for nurses to be more involved in the transfer of ECMO patients. This would provide increased clinical expertise for ECMO patients and was also a strategy to improve the cohesion of the team following the departure of consultants that nurses had known well. The introduction of a new post of an on-call ECMO nurse was intended to begin the process for developing the service.
- The clinical director and divisional nurse manager had a clear strategy to implement planned AICU care for all surgical patients and to develop the new service level agreement for ECMO patients with another trust. This was an opportunity to sustain and develop ECMO and to develop the hospital’s expertise and caseload. Although this plan was robust, comments from staff in the department indicated they were unaware of it and it had not been shared with them.

## Governance, risk management and quality measurement

- A clinical director, general manager and divisional senior nurse led the Brompton heart division, which consisted of AICU, the HDU, five cardiac care groups, anaesthesia and children’s services. The divisional director chaired the heart quality and safety committee which maintained governance oversight of all groups in the division. A critical care quality and safety sub-committee represented critical care services and anaesthesia,

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which included cross-site leadership. The AICU and HDU shared the same general manager and divisional senior nurse and each had a separate matron. Although the clinical governance structure was robust in principle, there was evidence of insufficient oversight in some areas. For example, a consultant providing sessions on the HDU had been appointed without the knowledge of the clinical director and a surgical consultant had admitted a patient there without the knowledge of the critical care consultant.

- Local unit governance was managed through a series of meetings. This included quarterly team days for training and updates from senior staff. Senior staff met every two months and the clinical educators met senior nurses every two months. Additional weekly strategy and operational meetings had been implemented in response to the candida auris outbreak.
- Theatre recovery was provided under the auspices of critical care and the AICU matron had responsibility for this area but it was led by anaesthetics staff. The HDU on Victoria ward was managed by the lung division. Clinicians we spoke with said previous plans to amalgamate the units had not been pursued and they were not aware of what the clinical director planned to do in the future. The general manager of the heart division attended meetings with the HDU medical lead but the AICU had its own quality and safety meetings that were independent from other critical care services.
- Consultants were involved in clinical governance processes. This included a monthly clinical governance meeting, quality meeting and management meeting. A new cross-site management meeting had been implemented with senior critical care staff at Harefield. Consultants and managers used this meeting to plan staffing to ensure the departure of a number of consultants from Brompton did not impact patient safety.
- There had been a significant number of resignations from the consultant body that had affected the operation of the AICU. This included the loss of nine consultant intensivists including seven ECMO-trained consultants. Seven clinical staff told us they felt the risks associated with this had not been managed adequately.
- Junior doctors were not routinely supported to conduct audits as part of quality improvement. A number of staff

said they were offered the chance to attend a journal club and there had been one audit opportunity that focused on accessibility to airway guidelines. After our inspection the trust provided evidence of the support offered to junior doctors, including educational support from faculty tutors and pastoral support. It was not clear if the doctors we spoke with were aware of these facilities.

- Risk registers were in place for critical care services. Senior staff used these to identify potential risks to patients, staff and service continuity. For example, one risk was about managing deteriorating patients around the hospital without a full time outreach team. Significant risks included the lack of space for secure storage that had led to corridors being cluttered and blocked and running out of consumable items. Staff had also highlighted the lack of space for bedside handovers and for multidisciplinary meetings as risks to the service. It was not always clear the risk register had been acted upon or updated regularly. For example, there were three entries on the risk register that related to problems with identity tags for patients. None of the senior staff we spoke with could explain why this was on the risk register although they did agree improvements had been made in using tags for patients in the recovery unit.
- Outcomes and changes to practice agreed in clinical and management governance meetings were not always completed. For example, the amalgamation of the ICU and HDU medical care teams was agreed in a quality and productivity meeting in 2014. This had not been initiated. The development of the ICU agreed in the trust strategic plan 2014 -19 had stalled and none of the staff we spoke with could explain the status of this. The creation of a cross-site critical care directorate favoured by senior clinicians in May 2015 had not received follow-up or support from senior managers.
- The lack of administrative support for junior doctors and clinicians in ICU was a regular item in management committee meetings. There was no evidence of an ongoing or planned resolution. However, after our inspection the trust told us that two full time administrators were available for junior doctors. It was not clear why the staff we spoke with were unaware of this.

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- The new on-call ECMO nurse role was implemented during our inspection period. This post was still in the development stages and we found staff were establishing this by learning during patient retrievals. For example, issues with equipment were identified during two retrievals including with staff knowledge and with carrying enough equipment. Staff told us they were concerned this had not been trialled before being implemented, which they felt posed an increased safety risk. After our inspection the trust provided more information on the development of this role, including safety protocols, training and supervision. For example, only nurses who had successfully completed a three-day ECMO course and undertaken critical care transfer training could take part. In addition nurses received one-to-one mentoring, in-house study days and attended feedback sessions.
- There was significant room for improvement in some areas of clinical governance. This included communication between consultants and communication between senior staff and those developing new roles and projects. For example, a surgical consultant had admitted a patient to HDU who was potentially put at risk because of a previous infectious patient in the bed bay. This occurred because the critical care consultant on duty was not aware of the incoming patient. This issue had previously been raised as a risk at clinical governance meetings without action. In addition, a new on-call ECMO nurse role had been implemented without a governance structure, job description or standard operating procedures. This meant nurses working in this role had no parameters for their responsibilities. There was no standardised check-list for checking equipment prior to a patient retrieval, no documentation for emergency trolley checks and no task list for staff on shift.
- The AICU matron ensured staff received a governance newsletter and drop-in sessions were organised to give staff the chance to keep up to date with changes in practice and policies.
- The critical care unit had not historically contributed to the intensive care national audit and research centre (ICNARC) programme which allows comparing clinical indicators with other hospitals. The hospital used data

from the northwest London critical care network to assess effectiveness of the service. The senior clinical team had begun to submit data to ICNARC and planned to use this in the future.

## Culture within the service

- Managers and other senior staff tried to develop and retain their own specialist staff to reduce the impact of shortages in certain professions such as physiotherapists. This was evident through the work of staff such as the therapy lead, clinical educators, HDU matron and senior sister.
- Some senior staff encouraged members of their team to take sabbaticals and study leave programmes. This helped to retain well-qualified and experienced staff while supporting them to pursue other professional and recreational interests.
- Some AICU staff spoke with us about a change in working culture that they felt had impacted staff wellbeing and their ability to work effectively. For example, one member of staff said the previous culture whereby everyone would help each other and look after each other had been reduced when a new senior clinical member of staff changed working conditions and rota flexibility. They said this resulted in a high rate of staff dissatisfaction and attrition and an increased reliance on agency staff. We corroborated this by speaking with staff about communication between them and the senior clinical team. Following our inspection the trust provided data that indicated a 19% reduction in the vacancy rate of staff and they told us use of agency nurses had reduced. It was not clear why there was a significant difference in perception.
- In total we spoke with 21 members of staff about culture and leadership in critical care. Staff in HDU and recovery spoke positively about working in that unit. Staff said they were supported, felt able to work to the best of their ability and felt the matron and senior sister were approachable. A number of staff in AICU said the tone and manner of e-mail communication from the senior team made them less likely to check messages regularly or to communicate themselves. Another member of staff said they felt communicating by e-mail was problematic because it had caused rifts between staff.
- Senior nurses told us as a strategy to improve relationships, the matron had started to attend team

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days and offer open forums for staff to discuss issues and ideas. We spoke with seven members of staff about this. They told us although this was a good start it had not helped to address their worries. They said, “The matron’s slot was brief and very business-like.”

- Members of staff who had joined critical care within the previous 18 months were positive about their experience. They described a very supportive nursing team with good access to clinical educators. Two members of staff said they developed their own coping strategies during the recent changes, adapted to the new environment and felt they had worked through a challenging period very well.
- Following the results of an internal staff satisfaction survey in which AICU staff satisfaction with leadership was only 6%, the leadership team organised group therapy sessions led by an occupational psychologist. The matron told us this was part of a number of measures to try and improve staff morale, including increased communication from HR to let staff know they could speak in confidence if they needed help.
- Staff nurses had opportunities to develop and progress. For example, band six nurses were offered leadership training and shift management opportunities. Senior HDU nurses were able to develop their leadership and clinical practice through a rotation onto a night practitioner programme in which they supported colleagues elsewhere in the hospital to manage deteriorating patients. The AICU clinical educators had met with each senior nurse to help plan the next stages of their career progression and to help them plan future training.

## Public engagement

- Staff sought feedback from patients in a variety of different ways and this was acted upon. For example, patients who took part in a follow-up clinic told staff their relatives had found the waiting facilities too small. As a result staff had found alternative accommodation for relatives and visitors, which had been refurbished. Patients and relatives on HDU had told staff they found it difficult to tell the difference between nurses and physiotherapists because they all wore a white uniform. As a result new nurse uniforms were introduced.
- The AICU ran a patient open day once each year, which typically accommodated over 100 patients and relatives.

This was provided for patients who had been treated in the unit to return and talk about their experience of treatment and recovery with staff. A consultant described this day to us as “essential” for listening to patients and understanding how practice can be improved. Staff had also supported the establishment of a peer support group using social media that enabled patients and relatives to communicate more easily.

## Staff engagement

- There was significant evidence senior staff had failed to act on risks raised by AICU clinical staff about concerns with environment and safety. This related to AICU patients being cared for in the HDU unit following a fungal outbreak. Seven members of AICU staff told us they felt this environment had been unsafe because side rooms were overcrowded with equipment that reduced their ability to access patients and increased the risk of infection. Staff also told us they felt this had presented a fire safety risk as they could not evacuate patients quickly if needed. All of the staff we spoke with said they had raised this with the matron and then the divisional nurse manager or clinical director without an adequate response. One member of staff said, “This was a dangerous situation. We asked to be provided with a clinical trolley for each bed for wound care, to at least reduce the risks of sharing equipment. [The senior team] were slow to respond and those of us working in the HDU at the time were not listened to. There was no presence of leadership.” After our inspection the trust told us senior clinical staff were on the HDU during every day beds were used for ICU patients and that this move had been completed with risk assessments in place. The trust said the senior team was readily available for staff to speak with and did not consider any of the move to be in any way unsafe. It was not clear why staff we spoke with were unaware of the presence of the senior clinical team.
- Findings from simulation learning exercises were discussed in unit meetings that were held every four to six weeks. Staff told us communication sometimes included educational posters produced by staff involved in learning and research exercises. We saw limited evidence of this in the units.
- Critical care consultants from the trust’s Harefield site had begun to work in the Royal Brompton site as an interim measure to address the loss of several



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consultants. However, five clinical staff told us they felt this process was not working well enough to manage the risks. For example, one member of staff said, “There is a huge rift between management and the clinical team. This is not a good situation.” Another member of staff said, “E-mails to the senior team have gone unanswered. The new consultants haven’t been introduced and they work in very different ways than what we’re used to. There’s been no oversight of the process and no communication with us.” Staff described a reduction in morale in the unit as a contributing factor to the resignation of a number of nurses. Senior staff told us they did not routinely collect information from staff about the reason for their departure. This meant there was no opportunity for them to learn from staff turnover. After our inspection the trust provided data that indicated nurse turnover had not increased during this period.

- HDU team meetings took place every four to six weeks and were repeated up to three times to make sure all staff could attend. The senior nurse led the meetings on an open forum basis that allowed staff to discuss concerns openly and to suggest ideas for improving the unit. The results of incident investigations were also discussed and the minutes of each meeting were distributed to all staff.
- Senior staff in HDU supported nurses who were interested in developing their critical care and leadership skills. For example, the matron had established a rotation programme with the recovery unit that meant HDU nurses with experience of caring for level two patients could spend time with level three patients under supervision. Nurses then completed a reflective exercise with senior HDU staff to plan their ongoing development. This process enabled nurses to develop professionally and senior staff to maintain consistency and retention of staff in the HDU.
- The HDU matron, as part of the unit’s vision and strategy, had asked staff to contribute to their own specialist professional development for the following three months. This information was used by clinical educators to plan training and by the senior team to structure patient care around staff experience and interest.
- An information board at the entrance to the AICU included the current staff sickness rate and the current

nurse turnover rate. It also included details of a recent complaint regarding the behaviour of a member of staff. This information was on public display alongside information regarding infection rates and the names of senior staff on duty. We asked six members of nursing staff about this. One senior nurse said the information regarding staffing was an incentive and positive intervention to help improve staff wellbeing, particularly mental health. Another senior nurse said it was a way to demonstrate to staff the senior team was doing something to support them during a period of high sickness rates. We observed a senior nurse during a handover point out the sickness rate to nurses starting their shift and described it as “unacceptable.” We saw this had a negative impact on the morale of the nurses starting work but senior staff said they felt they were very supportive of staff who had time off with sickness and did not encourage staff to come to work if they were unwell.

- An anaesthetist and the clinical director were dedicated leads for bullying and harassment. Some of the staff we spoke with knew there were clinical staff they could contact for support.
- As part of a project to improve end of life care, a nurse conducted a staff survey to find out about their concerns and needs in this area of treatment. The survey found staff needed support in understanding the ceiling of care and withdrawal of treatment, including which policies to follow. As a result, the palliative care team, consultants and spiritual care team provided more consistent, robust guidance to staff. Staff told us this had been beneficial and they hoped a better training programme for this subject would be provided as well.

## Innovation, improvement and sustainability

- Nurses led quarterly projects that focused on developing specific areas of care. For example, in the most recent project, nurses looked at improving sedation management in the AICU and worked with the palliative care team to improve end of life care in the unit.
- Clinical educators demonstrated an understanding of the impact of a period of uncertainty in the AICU. To address the additional distress patient deaths might cause to staff, they supported staff welfare through a









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process of emotional intelligence. For example, if a patient death was likely to cause a member of staff additional sadness because they identified with them in some way, such as by gender or age, the clinical educators offered staff private time to talk as well as the chance to meet a psychiatric liaison nurse for support.

- Clinical educators worked with their colleagues at Harefield to plan the implementation of an introduction to cardiothoracic critical care course to improve nurse skills and opportunities for development.

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

## Information about the service

Royal Brompton and Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK and among the largest in Europe and is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis. The adult and paediatric congenital heart disease unit was the first of its kind in Europe.

The trust has two main hospital sites: the Royal Brompton Hospital, which has 59 children's beds and Harefield Hospital children's outpatient department. A total of 4,035 children were treated as in-patients between September 2014 and August 2015.

Services for children and young people are located on the fourth floor in Sydney Street wing at the Royal Brompton Hospital. The department's in-patient ward (Rose ward) consists of 39 beds and specialises in the care of babies, children and young people, with heart and lung conditions.

Adjacent to Rose ward is the sleep ventilation unit with four beds used for sleep studies in children.

Paediatric intensive care unit (PICU) located on the same floor consists of 20 beds and specialises in care of children from birth to 16 years, who require level three care (16 beds) or level two care (four beds), following emergency and planned heart and lung surgery.

The children's service has schoolroom facilities. A playroom including a sensory area was available within the Rose ward. Teachers and play specialists also worked at children's bedsides when this was more appropriate.

There are children outpatient departments at both sites.

During the inspection, we visited all areas of the paediatric service. We spoke with fifteen parents, four children and 34 members of staff. This included support workers, nurses, senior managers, senior clinicians and the clinical lead. We observed care and looked at 10 records relating both to patients and the running of the service. Before our inspection, we reviewed performance information from, and about, the trust, services for children and young people.

# Services for children and young people

## Summary of findings

Overall we found the service for children and young people at Royal Brompton and Harefield Hospital as good because;

- The service had a robust process for ensuring incidents were reported and investigated. All staff were aware of their responsibilities to report incidents and staff knew about the duty of candour. The service had a positive incident reporting culture and staff received training sessions to learn from these. Learning from incidents was shared among teams.
  - There was clear evidence of innovative and outstanding practice that had won many national awards. Policies developed within the trust were being used nationally and internationally.
  - The paediatric service was caring. Staff treated children with care and compassion. We received positive feedback from all of the children and parents we spoke with. We were told that staff demonstrated a caring attitude and went beyond the call of duty to ensure both children and their family members received the best possible care.
  - Patient's privacy and dignity was maintained throughout their hospital stay. Staff ensured that children and their families were told about their care and were fully involved in any treatment decisions. Consent to care and treatment was obtained in line with legislation and guidance.
  - The service was effective. There were good processes to monitor patient outcomes and ensure that care was delivered in line with best practice. Ward staff worked well together to manage patients' pain. Staff on the wards monitored patients' nutrition and hydration and requested advice from a dietitian when required.
  - Children and younger people's individual needs were taken in to account and an excellent multidisciplinary approach was taken when delivering care and treatment.
- Every member of staff that we spoke with was passionate about providing the best care possible. There was an open culture and staff felt valued and well supported from the leaders within this department and the wider board.
  - The service had an open culture where incident reporting was actively encouraged and used for training to improve care. There were clear and effective governance arrangements.

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## Are services for children and young people safe?

Good



We rated safety in the children and young people's service at Royal Brompton and Harefield Hospitals as good because:

- There was clear evidence of safe recording of incidents and lessons learnt from these. Most staff were aware of duty of candour and evidence was seen of where it had been used.
- Staff understood their roles and responsibilities for safeguarding children and had systems for reporting.
- Children and young people were being treated and cared for in bright, clean and well maintained premises, by appropriately and well trained staff.
- Clinical areas throughout the hospitals were visibly clean and regular hygiene checks took place.
- There were clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Equipment was adequately maintained in line with manufacturer guidance.
- Patients received care and treatment from a team that demonstrated good awareness of risk assessment practice.

### Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents on the system. Incident reporting training was included in the staff induction programme, which all staff attended when they commenced employment at the hospital.
- The children services reported 767 clinical incidents between April 2015 to March 2016. Out of these 96% of these incidents resulted in no or low harm to the patient.
- There was one serious incident (SI) reported by children services in the reporting period, which was a surgical/invasive procedure incident meeting SI criteria. An investigation into this identified a known complication associated with cardiac surgery.
- There were no never events in the twelve months prior to our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Clear policies and procedures were in place to ensure that incidents were reported on the trust electronic reporting system, investigated and learning was shared. Incidents, complaints and significant events had been discussed at forums such as the ward meetings, clinical governance meetings and staff had on-going training sessions. For example, weekly in PICU and two weekly in Rose ward a multi-disciplinary group, review and plan actions following incidents.
- Junior doctors and nursing staff showed us how they reported incidents on an electronic incident reporting system and we were assured that staff were encouraged to report incident.
- Safety performance was monitored through monthly management meetings. This information contributed to senior management meetings where data collated on the incident reporting system was analysed to identify trends, newly presenting risks and those requiring escalation to the trust's risk register. Information considered included incidents and accidents occurring during work activities and safeguarding concerns.
- We saw evidence of action plans resulting from safety performance meetings and the corresponding changes in practice. For example, a number of children had been found to have missing identification name bands, which could have led to errors in treatment. We were advised that bands were often removed to gain access for treatment in emergencies and were not replaced in a timely fashion. There had only been one printer for both

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Rose ward and PICU capable of printing name bands. As a result, four new printers were purchased with wristband capability, there were monthly audits and 'walk rounds' to check identity bands were still attached. The most recent 'walk round' was in February 2016 and name bands had been 100% compliant.

## Duty of Candour

- Most staff knew of the duty of candour and were able to give examples of how they applied this requirement in practice. The Duty of Candour sets out some specific requirements that NHS providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Some junior staff did not always understand the terminology. However, the process they described in communicating with patients and their relatives reflected openness and transparency. Staff showed us the template letter used in response to an incident or complaint, which included an apology.

## Safety thermometer

- For the period April 2015 to March 2016 two pressure ulcers, one fall and two catheter related urinary tract infections (C.UTI's) were reported for the Safety Thermometer data. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- We observed that the patient safety thermometer data was discussed at the nursing handover. We saw evidence that safety thermometer data was used to improve the quality of care. For example, the numbers of days since last infections and falls was clearly displayed in Rose ward. However; no safety thermometer information was displayed on PICU.

## Cleanliness, infection control and hygiene

- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall mounted hand gels. However, the hand gel outside Rose ward had been missing due to repair work. We spent 30 minutes observing whether people entering the ward

used the gel. Nine of the ten people we observed entering the ward did not use the hand gel. This included medical staff. We discussed this with the lead infection control nurse who stated there was more emphasis placed on bedside clinical care. Each bay on the ward had hand gel outside and we observed staff using it on entering or leaving the bay.

- We noted good use of hand hygiene on PICU and good barrier infection control procedures being observed. However, this practice was inconsistent on Rose ward. We observed eleven out of twelve people did not use the hand gel when entered the ward and six staff did not use hand gel when entering or leaving the bays.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons were available and we saw staff using these appropriately. We noted that staff adhered to the 'bare below the elbows' policy in the clinical areas.
- Sharps bins throughout children's services were plenty and not overflowing. We also inspected the linen storage areas and noted that there was sufficient clean linen available.
- The play specialists we interviewed explained the system of toy cleaning and showed us the cleaning records. We saw the toy cleaning policy with clear processes. Staff showed good understanding of how to clean the toys and all toys were visibly clean and in good order.
- We observed domestic staff cleaning the department throughout the day in a methodical and unobtrusive way. We spoke with cleaning staff, who showed good understanding of separating different types of waste and the use of color-coding to dispose of waste.
- Staff had received infection prevention and control training as part of their annual essential training programme. Trust training statistics confirmed that 92.5% nursing staff in acute paediatrics and 94% of paediatric medical staff had completed infection control training in 2014.

## Environment and equipment

- We found clinical areas to be clean, well lit, bright and environmentally child friendly with appropriate equipment. The playroom on Rose ward and hospital school were well equipped with IT equipment and

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children's books. The large playroom was well equipped with toys, craft materials and distraction materials. The playroom was open 24 hours, seven days a week and children used the room out of hours under supervision of a parent or staff member. There was a well-equipped sensory area within the playroom.

- The safe ward environment included CCTV cameras and swipe card access only. Parents were issued swipe cards for easier access by senior members of staff. A contract had been written with approval from security and safeguarding to make parents aware of potential security risks such as "tail gaters" people trying to gain access behind them. It was ratified in March 2016 but awaited commencement until the new visiting hours advertised within it, wall signs had arrived.
- We saw equipment suitable for babies, children and young people in all clinical areas. The PICU and the other clinical areas of children's services had sufficient equipment to provide safe care.
- Paediatric resuscitation trolleys were available in all areas. We inspected the resuscitation equipment throughout children's services including children's outpatient department at Harefield. The trolleys were clean and secure, fully stocked and had been checked and logged on a daily basis. We undertook random checks on the resuscitation and other equipment, all had in date safety test stickers on them.
- The children's department main entrance and corridors were clean. The anaesthetic and pre assessment room was visibly clean and free of clutter. However, the environment on Rose ward was cramped with equipment in corridors due to no available storeroom. We discussed this with the senior nurse who told us "We have been victims of our success. We have outgrown our facility". Due to space issues, a business plan has been raised to build another seven beds on Rose ward.
- The environment for children's outpatient department on both locations was suitable for patients in both areas. Furniture was clean and water dispensers were available.

## Medicines

- We noted that medications were securely stored across all areas we visited.

- Pharmacists visited wards to clarify medication queries and check stock.
- Children who were admitted with their own medicines were seen by the ward pharmacist or pharmacy technician who checked, logged and verified medication then secured it in the drug cupboard.
- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Medicines management was effective. For example, medicines were stored in locked cupboards. Controlled drugs were stored in accordance with safe storage guidelines. Drug keys were kept separate to the ward keys with the daily runner for the ward, usually a supernumerary band six or above nurse.
- We reviewed seven medicine administration records and all were completed fully and accurately.
- The pharmacy team worked well with nursing and medical staff and were heavily involved in the MDT. Staff knew how to refer to the pharmacy team for advice. Nurses could describe to us how learning was disseminated to them from the pharmacist by way of newsletters, emails and attendance at department meetings.
- However, the room in which the medications were kept and the fridge temperatures had both been above the upper limit. This was raised with the chief pharmacist who told us that the shelf life of the medications would be less. None of the medications we saw had their expiry dates altered.
- The controlled drug book on Rose ward for oramorph had been entered as the prescribed dose milligrams and the total volume in millilitres. Although the stock amount was correct, this may lead to confusion.
- On PICU, on checking the drug cupboard, one box of metamamol was out of date. This was highlighted to the pharmacist and we were told that the incident would be reported to the electronic reporting system and investigated.
- In PICU, there was a pre-filled syringe of emergency medicine (adrenaline) kept on trolley for one patient,



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which allowed the nurses to access it quickly. However, this was not stored in any drawer on the trolley and was within easy reach of parents or anyone visiting the cubicle.

- The paediatric pharmacist told us that there was an incident where adrenaline was needed in an emergency and because right concentration was not readily available, it took too long to make up the dose. As a result of this, for relevant cases, 10ml adrenaline solution was now drawn up daily and kept on top of the resus trolley for emergency use in PICU. The pharmacist accepted that this was not best practice as there was a safety risk. The pharmacist has recently managed to source adrenaline prefilled syringe from a manufacturer with a 45 days shelf life and that this will then be kept within the resus box. The pharmacy team was working with the medical team to ensure this happens as soon as possible.
- The pharmacy team were well integrated into the multidisciplinary team, providing valuable contribution including research. E.g. the safe use of unlicensed medicine use as Posaconazole in children. They have also implemented self-administration of medicines for all children (or via their parents) with cystic fibrosis.

## Records

- We reviewed 10 sets of medical and nursing notes on both Rose ward and PICU and observed no shortfalls in record keeping.
- Records we looked at were detailed and evidenced up to date care plans. We saw evidence of parents and children being involved in decisions about their care. Records were complete and accurate. Hand-held notes were checked and found to be accurate, detailed and legible. An audit of care records was conducted on a monthly basis and any issues arising addressed with resultant actions disseminated to the staff through the ward meetings.
- The trust provided mandatory training on Information governance to staff. 100% staff had received this training and was above the trust target of 75%.

## Safeguarding

- All staff we spoke with showed in depth understanding of safeguarding children and what was required of them with regard to reporting concerns. There were clear policies and procedures in place, which included working with external agencies.
- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff told us that they had effective working relations with the local children's safeguarding and child protection teams and demonstrated a knowledge of what to do and who to contact should a concern be raised.
- Paediatricians routinely reviewed the records of children who miss appointments. G.P, community services and safeguarding team notified where there was concern that a child may be suffering neglect. Routine two monthly reviews of children were made for those giving concern by safeguarding team and paediatricians.
- Staff had access to the joint safeguarding and child protection registers.
- Intercollegiate guidance 2014 recommends that qualified clinical staff working with children and young people be trained to a level three standard in safeguarding. We were told that all staff had completed this. Nursing staff had completed safeguarding training as part of the mandatory rolling programme. A junior doctor told us that they had received safeguarding awareness (level one) training during their trust induction. Two other doctors told us they had completed either level two or level three safeguarding training. Safeguarding summary report 2015-2016 submitted to us showed that 100% of staff were trained in level three, 77% in level two and 85% staff were trained in level one children safeguarding training.
- The trust had robust outside supervision for the safeguarding leads nursing and medical. A programme for the nurses had been devised for group supervision which had been started. However, there was no supervision policy and contracts with the supervisor and the staff were not completed.

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- The trust had a child chaperoning standard operating procedure and staff showed good understanding of chaperoning a child to theatre and for accompanying a child for tests.
- The trust met the statutory requirements in relation to 'Disclosure and Barring Service (DBS)' checks. All staff employed at the trust underwent a DBS check prior to employment, and those working with children undergo an enhanced level of assessment.

## Mandatory training

- We talked with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, health and safety, medicines management and information governance.
- The trust training figures for 2014 confirmed that 94% of medical staff and 92.5% of staff in acute paediatrics had completed this training.
- The neonatal nurses were 89% compliant with basic life support training with senior nursing team having achieved the "New-born life support qualification".
- Senior nurse told us that there they had a new graduate nurse programme, which was a highly specialised programme for nurses graduating from university and taking up their first post at Royal Brompton Hospital's PICU or Rose ward. The programme included an initial week of classroom teaching, followed up by two months of supernumerary placed according to the nurse's needs.
- Each nurse had a mentor and was supported by and accountable to the educator until they join their established long-term team, led by a sister.

## Assessing and responding to patient risk

- Clinical areas were using their own risk assessment tool based on incident triggers.
- There was evidence of policies around safeguarding and domestic abuse, which included (FGM) Female genital mutilation. There were clear flow charts in place on reporting suspicions.
- Current standard for monitoring deteriorating patient is RCPCH standards, which integrate best practice and

incorporate paediatric early warning signs (PEWS), huddling and the SBAR. The Trust used a modified PEWS called 'Brompton Paediatric Early Warning Score' (BPEWS) which was a system used to monitor children and ensure early detection of deterioration. However, as this was a specialist hospital, most of the children have a score that was above eight that requires urgent clinical review. Therefore, children were given higher scores agreed by their consultant and was written in their notes and discussed daily at ward rounds and staff hand-overs. Staff told us they would escalate any concerns to medical staff. We reviewed ten paediatric early warning score observation charts and found these had been completed.

- Royal college of paediatrics and child health (RCPCH) standard states that at least one medical handover in every 24 hours should be led by a paediatric consultant (or equivalent). This standard was being met at Royal Brompton. There were daily consultant led ward round by paediatric respiratory and cardiology specialties.
- There were 25 nurses in PICU and 17 nurses on Rose ward trained in European advanced paediatric life support (EAPLS). All the in-charge nurses were either EPALS or APLS trained and there would always be one APLS trained nurse per shift on PICU, Rose ward and in paediatric recovery area as per RCN standards 2013.

## Nursing staffing

- There was a good level of skilled and knowledgeable staff to care for patients with complex needs.
- The trust assessed staffing levels and skill mix based on the Royal College of Nursing (RCN) Safer Nursing Care Tool (SCNT). Information supplied by the trust indicated that there were nursing shortages throughout. Adverts were in place for both wards with some interviews booked.
- However, the staffing numbers met the Royal College of Nursing (RCN) standard for safer staffing.
- Nursing staff advised us that staffing need was assessed daily for the following day and extra staff were booked as required. They used only one agency and had their own bank of staff therefore get the same nurses for continuity of care and knowledge. Most nurses used were neonatal and paediatric nurse trained.

# Services for children and young people

- The children's wards ran a six-month rotational preceptorship training for newly qualified staff to ensure staff were fully skilled in all areas. We were advised that this was going to be extended to a twelve-month preceptorship programme.
- To attract staff the trust offers London weighting, an amount of money added to the salary to help offset the cost of living and accommodation. Also for the first six months, new staff were offered single person accommodation in one of 170 flats available for a reasonable rent.
- There were daily two nursing handovers on PICU and Rose ward, at 7:45 am and 7:45 pm. We observed two nursing handovers and found these to be well structured and detailed. Staff flagged any risks for immediate response.
- The trust employed a team of 6.25 full time equivalent play specialists. There were dedicated play specialists for each paediatric area including wards, outpatients and theatres, but there was no play specialist at the outpatient department at Harefield, however, it could be organised as required by the Brompton Hospital.

## Medical staffing

- Information supplied by the trust indicated that at September 2014, the medical staffing skill mix across the trust was at 62 whole time equivalents (WTE) including 37% consultants and 63% registrars.
- Due to the specialist nature of the hospital, most doctors employed were registrar or consultant level. The medical staffing skill mix for the trust had slightly more consultant and 12% more registrars compared to the England average.
- Trust wide, the RCPCH standards were met as the trust provided paediatric consultant cover on site up to 10pm.
- The medical team were on-site 24/7 with on-call consultant cover who was able to attend to emergencies promptly.
- Two anaesthetic consultants had a paediatric interest. We were told that there was always an anaesthetic consultant or intensive care specialist available out of hours to provide anaesthetic advice and support for children's services.

- We observed two paediatric handovers and saw that they were thorough; records of doctors' attendance were documented.

## Major incident awareness and training

- The trust had a business continuity plan (undated) which ensured that critical services could be delivered in exceptional circumstances.
- A trust major incident policy (2015) was in place. This policy identified what measures would be put into place should a major incident require paediatric expertise.
- The children's wards had planning in place for when they were at full capacity or in bad weather conditions. Escalation guidelines were also included in this document.
- The staff received full evacuation training every three years from the London Fire Brigade and liaised with the hospitals fire officer for standard fire training and updates.

## Are services for children and young people effective?

Good



We rated effective for children and young people service as good because;

- We saw clear examples of evidence based care and treatment being given.
- Pain relief was being administered in a timely and effective manner. Children and babies were receiving good levels of hydration and nutrition.
- Department was taking part in many local and national audits to help improve patient care and outcomes. NHS England had worked closely with the trust on a number of areas for quality improvement that have been monitored at the clinical quality review meetings.
- Care was being provided by competent well-trained staff in all areas inspected.
- There was good evidence the service was working closely with external providers who enhanced the multidisciplinary team approach to care.

# Services for children and young people

- Consultants were available round the clock to offer advice and assistance where required and we saw that informed consent for procedures was being obtained in all cases.

## Evidence-based care and treatment

- We reviewed 10 sets of care records both on the electronic system and hand-held across the clinical areas inspected. Records were detailed and easy to understand. The electronic system contained entries from the multi-disciplinary team. All records were reviewed were in line with the Nursing and Midwifery council guidance on record keeping.
- We saw examples of national guidance being followed. Both PICU and Rose ward were compliant with level three “Baby Friendly Initiative” for breast-feeding.
- The trust’s hospital protocols were based on NICE and relevant RCPCH guidelines. Local policies were written in line with these. Staff showed us how they accessed guidance, policies and procedures on the trust intranet. However not all guidelines had been kept up to date. For example, for PICU ten guidelines were out of date and two had no review date, on rose ward ten nursing guidelines were out of date, including assisting with extubation (no review date), tracheostomy suctioning (no review date), chest drain removal (2009), PICU guide (review date April 2015), administration RBC (December 2013) and insertion insuflon (December 2013).
- Assessment and treatment given and care interventions based on the latest NICE and Special Educational Needs and Disability (SEND) guidance for children with complex needs.
- We saw evidence the department was taking part in local and national audits for example: - infection control, medication management, survival following childhood mitral valve replacement, The management of serum vitamin D levels in children with cystic fibrosis and the Children’s Survey.
- The trust scored similar to other trust in the Children's Survey 2014 for six of the eight measures within the effective domain. Data for eight to 15 year old children and young people were not available.

- However, the trust does not participate in the British Thoracic Society (BTS) acute asthma audit because the Trust does not provide an acute asthma service. The asthma service at the trust is a specialist service for patients with difficult asthma.

## Pain relief

- We observed that a pain assessment tool was in place to identify and manage pain in children. The pain assessment chart was readily available in each patient’s clinical records.
- There was access to an anaesthetist 24 hours a day seven days per week to advice on paediatric pain relief.
- We saw nurses using a distraction therapy approach for children and young people, which was led by the play specialist. This was a way of helping a child cope with a painful or difficult procedure.
- The department used Kangaroo care (a technique where the baby was held skin-to-skin with the parent) in caring for not too sick patients, as a means of helping to stabilise babies.
- We spoke to a parent who told us that the pain relief for his child had been “Fantastic”. His child had been taken from school to a nearby A&E and transferred to the Royal Brompton. The child had been in a great deal of pain, which had been brought under control promptly. The parent told us “We could not have wished for better”. The child told us “I can have a tablet if I need it but I didn’t have the pain anymore. When I did, all I had to do is ask and the nurses gave it to me”.

## Nutrition and hydration

- A variety of food choices was available to children, which included a selection of snacks.
- Most children we spoke with told us that the food was “nice”, however one parent described it as “Stodgy and not very nutritious”.
- We saw that food and fluid balance charts were being used correctly to help maintain nutrition and hydration.
- There was a breast-feeding room on PICU and a milk kitchen with breast pumps and fridges available.
- We saw a thank you card from a mother who had experienced problems breast feeding and had received help and support, simply titled “Expressing Myself”.

## Patient outcomes

# Services for children and young people

- There was no evidence of risk that the trust was an outlier regarding paediatric and congenital disorders.
- The trust was clearly benchmarking outcomes against National clinical outcomes. For example, emergency readmission rates for elective procedures within paediatric cardiac surgery, in the under one age group, were slightly higher than the national average. There were emergency readmissions after elective admission among patients in the 1-17 age group between November 2014 and October 2015, however no more than six readmissions were reported per speciality.
- Children's services submitted a range of data to national audit programmes. This included the Paediatric Intensive Care Audit Network (PICANet), NICOR congenital heart disease audit and UK Cystic Fibrosis Registry.
- The PICU has routinely participated in the PICANet programme. From Quarter 1 2015/16 to Quarter 3 2015/16 overall there were no discernible trends for seven out of the eight PICU indicators.
- The rate of accidental extubation of patients has been consistently better than the national average since mid-2013, however there was a decrease in performance from quarter 2 2015/16 into quarter 3 2015/16 where the trust dropped from the upper limit to performing within expectations.
- Refusal rates for emergency admissions were in the lower limit when compared to the national average in both Q1 2015/16 and Q2 2014/15 although performance improved in Q3 2015/16 to within expectations.
- The data showed Quarter 3 2014 -2015 risk adjusted mortality was 0.86 and in quarter 3 2015 -2016 was 0.89 which was lower than national mean (1). The outcomes for this unit fall within the selected confidence limits and therefore Royal Brompton Hospital PICU can be described as having a case mix adjusted mortality rate that falls within the expected range.
- The PICU specialised service quality dashboard data for Quarter 3 2015-2016 showed emergency readmissions to PICU within 48 hours was lower (1.23) than national average (1.5).
- Cancellation of elective surgery due to bed unavailability was lower (2.3) than national average (11.4) for the same period.
- The congenital heart disease outcome data for March 2015 – February 2016 showed that 30 day survival rate for the unit was slightly higher 97.8% than the expected rate of 97.5%.
- The crude in hospital mortality during March 2013-February 2016 for congenital heart disease following cardiac surgery was 2.8% and following cardiac intervention was 1.2%.
- NHS England had worked closely with the trust on a number of areas for quality improvement that have been monitored at the clinical quality review meetings. They noted some areas of good practice in – service improvements in human factors training, and paediatric long-term ventilation care. Plans worked on closely with the trust included a continual improvement plan to support the clinical and system wide engagement for the transformation of care at this specialist trust.
- NHS England was considering the outputs following the new congenital heart disease review and will be working with the trust when the outcome is announced. The cystic fibrosis service for adults and paediatrics is the largest in Europe; this creates a number of challenges for the review and monitoring of shared care and network centres. NHS England works with the cystic fibrosis peer review process led by the British Thoracic Society and the Cystic Fibrosis Trust to review quality standards in the service.
- Emergency readmission rate for elective procedures with the paediatric cardiac surgery, in the under one age group were slightly higher (1.6) than the England average (1.1) between November 2014 and October 2015.
- There were emergency readmissions after elective admission at Royal Brompton and Harefield NHS Foundation Trust among patients in the 1-17 age groups between November 2014 and October 2015. However, no more than six readmissions were reported per speciality.
- There were less than six readmissions among children and young people for asthma, epilepsy and diabetes between December 2014 to November 2015. Numbers below six were removed for confidentiality purposes.



# Services for children and young people

- There were no emergency readmissions after emergency admission at Royal Brompton and Harefield among patients in the under one age group between November 2014 and October 2015.

## Competent staff

- The NHS national staff survey 2014 showed that 100% of staff across the trust had received job relevant training/ learning within the previous 12 months.
  - Newly qualified nurses rotate within the network one-year preceptorship programme. The preceptorship programme was complementary to the new graduate programme, which lasts up to 6 months.
  - Student nurses gave us very positive feedback saying they felt fully supported throughout their placements. Regular training sessions were held with regards to cardiac and respiratory conditions, diabetes, and oncology. Protected time was given for all staff to attend.
  - The annual staff appraisal matrix was seen for Rose and PICU only two staff were outstanding, one on maternity leave and one on sick leave. The NHS national staff survey figures showed that 81% of staff across the trust had received appraisals within the previous 12 months.
  - Staff told us that although they received regular clinical teaching sessions on the wards there was no formal supervision in place. We discussed this with the senior nurse and one of the seven clinical practice educators. We were shown an implement training and supervision schedule planned to start in June 2016.
  - Staff told us they were happy with the training sessions they were encouraged to attend. However, for revalidation reasons they were looking forward to a structured and documented supervision schedule.
- All staff told us they felt part of the clinical team and Royal Brompton family.
  - There was a multidisciplinary approach to audit and governance within the service. People had been allocated lead roles in relation to quality and governance for senior clinicians in the service.
  - The paediatric rehabilitation and therapy team worked directly within the multi-disciplinary team, co-operating with health and nursing to ensure co-ordinated care was planned and delivered to meet the needs of the individual families.
  - The advance nurse practitioners (ANPs) in PICU worked alongside the medical team and were responsible for a group of patients and provided clinical and educational support both to the nursing and junior medical team.
  - External MDT work included sharing learning outcomes with other hospitals. There was sharing of best practice at many levels of nursing care, rotation of nurses between units, between the wards, Paediatric high dependency unit (PHDU) and between PICU and a neighbouring NHS trust neonatal intensive care unit (NICU). Clinical nurse specialists (CNSs) work directly with staff there and they share their expertise in general paediatrics with the Royal Brompton. There were collaborative education programmes and a new, dynamic approach to innovative practice such as sharing advanced nurse practitioner expertise to raise understanding, help stabilise neonates with cardiac lesions and strive for excellence in transferring neonates between all units.
  - Transition pathways were in place for cardiac and cystic fibrosis (CF) children. The cystic fibrosis (CF) transition pathway starts at 14 years, acknowledgement of the individuals understanding CF was continued throughout this process, which promoted independence and recognition of parents and their feelings towards transition.
  - At age 16, the young person was invited to a transition clinic, where they will meet with both their paediatric team and be introduced to their adult team. This may not trigger transfer and some young people prefer more than one attendance before they were ready.
  - Two CNS's for the CF hospital to home team told us they were are very lucky and had a "unique service" as

## Multidisciplinary working

- Multidisciplinary team (MDT) working at the Royal Brompton and Harefield hospitals was exceptional. All disciplines worked closely with each other and no one was excluded from consultants down. Everyone we spoke with was committed to delivering the best possible outcomes and care. We spoke with physiotherapists, speech and language therapist, the family liaison officer and discharge planner, cleaners, porters, all levels of nurses and doctors.



# Services for children and young people

children who transition to adult care were able to access adult services within the same hospital. They start talking to children about transition when they reach twelve years old. One CNS told us “We are so lucky. We become one of the families and sometimes support other siblings from the same family”. The team ran transition days, open to the whole family, hold joint clinics, and had trips to adult services. “We are working to build standards of care for CF patients and the CF clinical guideline produced at The Royal Brompton are used all over the world”.

## Seven-day services

- Twenty-four hour paediatric consultant support was in place. Weekly rotas were available regarding which paediatric consultant to contact. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff said they could access out-of-hours investigations, for example, imaging and urgent laboratory tests. We were also told that pharmacy access and support was available.
- There was a multi-agency safeguarding hub in place responsible for co-ordinating out of hour’s enquiries.
- Play specialists and all other allied health professionals were on the ward seven days a week.

## Access to information

- Information leaflets were available on a number of health topics including asthma, bronchiolitis, CF and a range of cardiac conditions. These were available in both inpatient and outpatient settings in both hospitals. However, staff told us they could not access leaflets in other languages.
- There was good use of interpreters via “One Stop” for parents of children who spoke little English. For outpatient appointments, interpreters were booked in advance. On the ward areas, interpreters were booked as required.
- Health promotion information and access to local services was available for children and young people. We saw child friendly leaflets with bright colours and large print with pictures.
- Information on how to access hospital services was available for people to access.

- Ward and outpatient areas displayed some trust policies. All other policies and procedures were available and could be accessed by staff from the trust’s intranet.

## Consent

- A survey had taken place on the Royal Brompton site, as part of the quality improvement 2015 called “Evaluation of the Processes to Consent to Treatment”. Results showed unanimously that people were happy with the consent process.
- We found that consent to treatment for patients was obtained following the correct guidelines and procedures. All staff spoken with were aware of the trusts consent procedure and could describe the legislative requirements regarding consent in young people. Staff were able to describe Gillick competencies and the requirements for seeking consent from children and young people when they had been assessed as competent to make decisions about their care and treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger was competent to consent to medical examination or treatment without the need for parental permission.
- We spoke with staff, who confirmed that patient consent would be sought prior to any procedures or tests being undertaken. Children and parents we spoke with told us that they had been involved in decisions relating to the treatment offered to them.
- Parent of one child who had an operation confirmed that both the surgeon and anaesthetist explained the procedure, checked the parents understanding of the procedure and confirmed that written consent had been obtained.

## Are services for children and young people caring?

Good



We rated the service for children and young people as good for caring because;

- We observed many examples of compassionate and understanding care being delivered by friendly, approachable and committed staff.

# Services for children and young people

- We heard extremely positive comments from most parents, relatives and children who used the service.
- Parents were supported to have an active role in the care of their child. They were encouraged to ask questions and learn how to support their child or baby prior to discharge. Discussions with patients and families were evident in all of the medical records that we examined and family involvement was also discussed in the handovers.
- Staff were putting children at the centre of their care.
- Friends and Family Test (FFT) results were consistently above 90% across the department.
- In the children's survey 2014, the trust scored similar to other trust for 21 of the 36 caring measures.
- Play specialists supported children by preparing them for treatment and teaching them coping strategies. Singing therapist sang songs to children who were having their bloods taken.
- However, some families members told us although the care was good on paediatric high dependency unit (PHDU) and Rose ward, the staff were not as helpful, informative or as friendly as the staff had been on PICU.

## Compassionate care

- Staff had a caring, compassionate and sensitive manner. We saw staff playing and laughing with children and talking to the babies whilst performing observations.
- Parents told us they were able to accompany their children to theatres and recovery areas and ward staff informed them when their children were out of theatre so they could re-join them to help lessen anxieties.
- The feedback from children on the children's ward was all very complimentary about the care they had received from doctors and nurses. One child commented, "I like it here. The school is really good and I get to go on the internet until 9pm. Also we get to go to the youth club twice a week". His father said "He truly doesn't want to come home he had so much fun" the child smiled and nodded.
- The children's survey 2014 data mirrored that of other trusts. However, data collected from 8-15 year olds scored higher than other trusts. The trust scored better than other trusts for four measures. These measures

included questions related to staff playing with children whilst in hospital, encouraging parents to be involved in the child's care and decision-making and staff informing parents with regard to hospital stay, operations, and procedures. However, no scores were provided for ten measures in relation to eight to 15-year-old children and young people.

- The children's patient survey was printed with pictures for ease of understanding at any age. The results showed that questions relating to caring scored the same as other trusts. However, the question relating to "Do patients feeling listened to" was better than other trusts. One child told us, "I have been in lots of children's hospitals but I like it here best".
- Both Rose and PICU were taking part in the "Friends and family" survey and how likely would it be for them to recommend this service to friends and family. Both wards had consistently scored above 90% over the past twelve months.
- Another parent told us "The care has been brilliant. I am not allowed to stay with my daughter overnight because it is ICU- but other than that, my husband and I can stay or go at will. Other visitors are regulated to specific times but that is partly our choice as well. I feel that the doctors proactively ask my opinion".
- There were many cards and pictures in the department from former patients and parents that had utilised the service, commenting on how good their care experience had been and how dedicated the staff were to their roles.
- We spoke with six families, five parents, three grandparents and four patients who all told us they had received compassionate and thoughtful care and advice whilst their children were on PICU. However, three parents told us they had felt slightly let down on Rose ward. Their comments included not being informed where facilities were for parents. One parent said "The staff on PICU are really good at explaining what is going on and what they are planning to do and why. On the Rose HDU we had to be more proactive to get the information".

## Understanding and involvement of patients and those close to them

# Services for children and young people

- One parent told us “The medical staff, nurses to top doctors, obviously have their discussions in medical speech but then explain to us what is going on, what will be done and why and what they expect to happen”.
- We noted excellent practice with play leaders who explained pre-operation procedures to small children via storybooks showing them airways and other equipment with use of dolls to help lessen anxiety and helped to prepare children psychologically for theatre and procedures.
- Discussions with patients and families were evident in all of the notes that we examined, including in discharge planning, decisions to transfer to other hospitals and gaining of consent. Family involvement and education was also discussed in the handovers that we attended in each ward.
- We observed parents were actively encouraged to gain skills in caring for their babies for example undertaking tasks such as nasogastric feeding.
- We saw a singing therapist who sang songs from “Frozen” to children who were having their bloods taken. In the outpatient department at Harefield, we saw a clown making balloon models for children and their siblings whilst awaiting appointments.

## Emotional support

- There was a paediatric clinical psychology service for the paediatric department. The service included supporting parents expecting a prospective patient (antenatal), offering bereavement counselling to all families of any child patient who has sadly died and at any time in between. The lead psychologist told us that they were there for staff as well as patients and relatives but their biggest caseload was counselling relatives who have a sick child.
- There was also a counselling and family liaison service ran by nursery nurses who told us “I realised that the parents wanted someone independent to talk to. The psychology team do a good job but I thought we could offer something different. I now have two colleagues working with me, one full time and one part time. We are unique in being a non-medical team of nursery

nurses for cardiac children. I have been running the service for twelve years. We have leaflet to inform the parents about us although it is currently being redesigned”.

- Clinical nurse specialists for cystic fibrosis (CF) told us they offer on-going emotional support to families prior to, during and when they leave the hospital.

## Are services for children and young people responsive?

Good



We rated responsive for this service as good because;

- We saw clear evidence that the service was being planned to meet the care need of not only local but national and international children and their families.
- There was good access and flow to the service with open access for children with chronic conditions. The service was meeting the needs of children with long term chronic and life limiting conditions by working in collaboration with other hospitals and hospices.
- The trust had a clear complaints procedure in place for when things go wrong and although this information was given to parents in a pre-admission pack some parents told us they would not know how to make a formal complaint.

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

- The Royal Brompton and Harefield children services were taking referrals nationally and internationally. This meant that although they were clearly meeting the needs of local people their remit was far wider.
- We observed other departments across the hospital where children and young people would visit as part of their care and treatment. The majority of these areas were equipped to be ‘child friendly’, such as the dedicated operating theatre, waiting area and recovery area.
- The paediatric cystic fibrosis home care team was set up for local people in 1998, over the next five years paediatric respiratory, paediatric cardiac and paediatric inherited cardiac conditions home care teams were

# Services for children and young people

established. The clinical nurse specialists all manage caseloads. Home or school visits were arranged according to child's need. Frequently the CNS co-ordinates such visits with allied health professional (AHP) colleagues, such as physiotherapist for a child with CF or will arrange a home visit with the health visitor or community nurse for supporting on-going care in the community.

- The trust had children's and adolescent mental health liaison services (CAMHS) service level agreement with neighbouring NHS trust, related to both children and young people aged less than 18 years and their family members or carers. The service provided urgent and routine care, which was available "in hours" and "out of hours". However, there were no CAMHS patients admitted to the paediatric ward over the last 12 months, as being a tertiary referral cardio-respiratory care hospital they had no mental health beds. Children with mental health needs could be admitted and cared for by appropriate professionals at the neighbouring NHS hospital.

## Access and flow

- From April 2014 – March 2015 there had been 181 admissions to children critical care. During same time period there were 37 refusals to the children in-patient service. The refusals were due to lack of beds. The trust had put forward a business plan for seven new beds spaces to be built and had the agreed joint funding. However, there was no definite commencement date planned.
- PICU and children's services generally provided good access and flow to its services. Children with long-term conditions had open access to the paediatric ward and close links with the hospital to home CNS's in every speciality.
- There were various admission processes on to the Rose ward within this trust, including from A&E departments in other hospitals both locally and nationally, G.P's and the community nursing teams. Apart from this the service took international and national private referrals. Bed occupancy was always high.
- There had been no discharge protocol for new nurses to follow, only the trust wide discharge policy. Therefore a new policy and proforma for paediatric was produced, which was more robust and addressed the specialities

and sub-specialities for discharge. The new discharge planner, which was on trial, covered all discharges in each speciality. The planner started at admission to reduce delayed discharge. It had a comprehensive checklist and there were plans for the completed form to be available in languages other than English.

- In the paediatric outpatient department on both sites, clinics were rarely cancelled with less than six weeks' notice. In this case, the appropriate medical secretary to reschedule their appointment would contact them. If a patient cancelled an appointment, staff were usually able to reschedule this immediately.

## Meeting people's individual needs

- Photographs and names of ward staff were clearly displayed in each ward.
- Laptops and mobile phones were allowed on Rose ward for older children.
- The family liaison officer told us that some of the main anxieties with having a sick child at the Brompton for parents were often financial, accommodation and parking. The trust therefore offers one of five parking spaces that can be allocated to parents or accommodation to help alleviate this.
- Families of sick children faced problems with accommodation; therefore, the trust provided parent accommodation, within the hospital and close to it. The family liaison manager told us "We are able to provide accommodation for parents and sometimes their other children on site. We currently have seven twin bed rooms (one en-suite) with access to a kitchen, microwave, fridge, washing machine and TV) on level six, two floors above PICU. Priority is given to new caesarean section mums (en-suite) and PICU parents. In South Parade, a short walk from here, we have eleven rooms including a family room with four beds, on level one and nine rooms on level two, three singles and six twins. The accommodation and parking is free to NHS parents but private parents pay. Priority is given on clinical need not the ability to pay".
- The family liaison manager also had access to five car parking spaces, which can often stretch to seven. "Usually we negotiate with parents over parking space or accommodation. Very occasionally we allow parents both in exceptional circumstances".

# Services for children and young people

- Parents we spoke with about the accommodation told us, it is basic but a home from home. One couple told us “We don’t know what we would have done without it”. Another father said, “This is a piece of normality in a totally abnormal situation, I can’t imagine what life would be like if we didn’t have this place”.
- Halal and Kosher food options were available. There was a kitchen on Rose ward and included microwaves, toasters and kettles. Daily meals were offered to new mothers in the PICU, with consideration given to specific dietary requirements. Specially designed paediatric menu was available. Children food was made on the premises by special diet chef and would made food by request for children who wanted something special. Special diet also included allergy diets and high fat CF diets.
- New mothers who were expressing were entitled to take food from the trolley; the family liaison officer also had meal vouchers to give to parents if required.
- Trust informed us that they increased en-suite facilities by building a new cubicle with toilet and created four fully en-suite cubicles by splitting the two existing bathrooms. Children’s services also split playroom to allow more access for CF patients.
- The Paediatric Rehabilitation and Therapy team provided specialised service aimed directly at supporting children with cardiorespiratory disease. The team included speech therapists, physiotherapists, occupational therapists and dietitians.
- Access to interpreters or language line was available where required. The hospital can access a translation service for people who speak a language other than English.
- Children with learning disabilities are currently not being flagged on admission. However, most children were known to the service and their problems were well known.
- For ease of communication for children with tracheostomies and deafness all play specialists have attended “Makaton” basic sign language training.
- Play specialists supported children by preparing them for treatment and teaching them coping strategies. This reduced the anxiety of the child and increased treatment compliance.

## Educational Services

- On fourth floor Sydney wing street, there was the Chelsea community hospital school. Both primary and secondary school rooms were open during school hours in term time. There were two full-time teachers and a learning assistant and provided education for infant, primary and secondary years.

## Learning from complaints and concerns

- Complaints were handled in line with the trust complaints policy. We noted that clear information was given in the elective pre admission packs to inform people how they may make a complaint or contact the patient advice and liaison service (PALS).
- There were only three formal complaints for the paediatric department between April 2015 and March 2016. These were related to admission, discharge and transfer arrangement and clinical treatment. Data provided indicated that all of these complaints were dealt with in an appropriate and timely manner.
- The senior nurse told us that there are very few complaints, and most can be and were handled at ground level.
- Complaints were discussed at the children’s services quality and safety committee meetings. Outcomes and actions were disseminated to staff through formal and informal meetings.
- However, two family members told us they would not know how to make an official complaint.

## Are services for children and young people well-led?

**Outstanding**



We rated well-led for this service as outstanding because;

- There was clear evidence of research, innovative and outstanding practice. The Simulated interPROfessional Team training (SPRinT) had won national awards with many hospitals both nationally and internationally running and planning to run the programme.



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- Individuals had clear visions and strategies for the service. The leadership of the service was cohesive, transparent and visible to all staff members.
- The service had an open culture where incident reporting was actively encouraged and used for training to improve care. There were clear and effective governance arrangements.
- Staff and public engagement were sought via satisfaction surveys for staff, parents and children.
- The Brompton policies were being used internationally, for example, the Cystic Fibrosis (CF) policy and guidelines were used and had International acclaim.

## Leadership of service

- The divisional directors for lung and heart and a general manager along with two co-directors and a team of clinical leads, matrons and other leads led the children's services.
- There was good local and trust wide leadership of the children service. This was demonstrated by staff who told us of many ways they had been supported locally by their ward and senior managers.
- Trust members were visible. Every member of staff we spoke with could name the CEO and at least one other board member. We were told by staff on Rose ward, that the CEO did monthly walk rounds to meet families, patients and staff.
- Every member of staff that we spoke with told us that the leadership team within this trust had made significant improvements over the past four years.
- We were told of ideas that had developed within this service and been shared across other parts of the trusts and hospitals as areas of good practice.
- Our discussions with managers demonstrated that they were passionate, committed to delivering outstanding research based and quality focused patient care.

## Vision and strategy for this service

- We saw official documented vision and strategy for this service with a clear mission statement "To be the UK's leading specialist centre for heart and lung disease". All staff spoke enthusiastically of plans for the future.

- Senior staff we spoke with were aware of the trust vision, how it linked with departmental vision and strategies, associated challenges and plans.
- Staff we spoke with had their own visions for the future to improve their service to make it the best it could possibly be.

## Governance, risk management and quality measurement

- There were arrangements in place for governance, risk management and quality measurement associated with the care of babies, children and young people across the trust. The service held regular governance meetings where good practice was shared and issues relating to the service discussed. Action planning took place so that identified improvements could be made.
- Staff were able to tell us about the department governance arrangements and which individuals had key lead roles and responsibilities within the department. They were clear of their own individual roles and responsibilities and where to access information from when needed.
- There was a comprehensive audit programme. A number of audits were undertaken regularly in the children services, which provided assurance that delivery of services were in line with national guidelines and the service could measure its quality against patient outcomes. The department undertook monthly audits of its compliance with safety thermometers and these ward assurance results were displayed on safety boards within the ward, including feedbacks from patients and visitors.
- We reviewed the CYP service risk register. There were five risks on their register including, overcrowding on Rose ward and possible delay in emergency drug administration. Each risk had a grading depending on the severity of the risk, there were details of the lead person responsible, action taken to mitigate the risks and progress was recorded, demonstrating active management of identified risks. We saw minutes of departmental meetings, which contained evidence of discussing and reviewing their risks registers.



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- We saw that patient feedback was regularly assessed and reviewed. Feedback was regularly reviewed and there was evidence, which demonstrated actions were being taken as a result of the feedback.

## Culture within the service

- Staff told us that the hospital had an open culture and actively encouraged reporting of incidents when things went wrong. All staff understood how this could influence positive service change and improvement.
- Staff told us that they would always receive feedback and support from their managers and team members where this was necessary. They told us that all incidents were used as learning tools for the future. We saw files with incidents, which had been reported on the trust electronic reporting system with learning outcomes underneath.
- Staff we spoke with told us that morale within the service was very good with comments such as “We all feel part of the Brompton family”. Staff told us they felt valued and many reported being thanked and felt appreciated for the work that they carried out. Staff commented it is always busy, however no area was ever understaffed and we are never denied extra staff to cover if it is required.

## Public engagement

- We saw various initiatives in place to gain the feedback of children and their families. One initiative was the “friends and family” initiative “would this be a good place for your friends and family to come to if they were unwell”. Comments from this read, “Staff are very friendly, professional and make you feel very welcome” and “Brilliant care, excellent medics”.
- Children were encouraged to complete the children survey form. This feedback was displayed throughout the service and via booklets “Your survey results 2014” which were available in all areas.
- Nurse led support groups were in place for example: - BEST – breast-feeding group, Complex care group – ‘all about me’ and a Palliative care group.

## Staff engagement

- Staff took part in the annual NHS staff survey. Results for 2014/2015 were seen and 77% of staff agreed they would recommend their organisation as a place to work.
- One non-clinical staff member told us “I feel that I am part of a team here, the other staff know my name and we all work together”. All staff we spoke with told us they felt fully engaged in every aspect of their work and continued training.

## Innovation, improvement and sustainability





- The Royal Brompton and Harefield Foundation Trust has received national and international awards and acclaim for its research. The Brompton policies were being used internationally, for example, the Cystic Fibrosis (CF) policy and guidelines were used and had International acclaim.
- Staff nurse development programme called ‘New Graduate programme’ facilitated good post grad experiences for newly qualified nurses. It is a competency based programme of lectures and beside teaching which compliments the preceptorship programme. This approach to supporting and training graduate nurses, enabling them to care for children with complex needs in a supported and sustainable way.
- The children's services had a complex care quality initiative called ‘All about me’, which recognised the complex needs of child and family. Each child was allocated a team with a nursing and medical lead and parents were encouraged to participate.
- The Simulated interPROfessional Team training (SPRinT) programme started at the Brompton in 2008. Its main aim was to increase awareness of human factor training so that patient care and safety could be improved. Their vision was to engage all healthcare staff in order to attain real improved patient safety and outcome through improved team working and crisis resource management. This was achieved by performing crisis simulations as close as possible to the real event, for example paediatric resuscitation.
- SPRinT training had won National awards, for example, Health Business Awards Commendation 2015 for patient safety, shortlisted for Health Safety Journal Award 2015 for patient safety, 2015 President’s Prize Royal Society of

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Medicine: “Frontiers: Simulation in Cardiothoracic Surgery,” 2015 ASPIH Best Short Communication Winner and 6th July 2015 The Birmingham Patient Safety Awards, winner.

- Delegates attend the training from all over the world. The training has been taught and has commenced at other hospitals nationally with international interest. Team members will be taking the model overseas later this year.

# End of life care

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

## Information about the service

End of life care (EOLC) relates to patients who have been identified as having entered the last 12 months of their life or less. It refers to care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness that has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and other illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care at the Royal Brompton is provided at by a specially trained team of doctors, nurses and others who work together with other health service staff to support people at the end of their lives.

The specialist palliative care team at the Royal Brompton site is made up of two clinical nurse specialists, a 0.8 working time equivalent (WTE) consultant, junior doctors and other allied health professionals to provide care for patients in the final phase of life.

There were 151 adult deaths on wards at the Royal Brompton hospital in the year April 2014 to April 2015. The majority (59%) of these deaths occur in the critical care environment, where patients are generally ventilated and sedated.

There were 274 referrals to the specialist team in the same year.

The Royal Brompton does not have any dedicated hospital beds for patients who are dying. Patients in the last days or hours of life were cared for in a side room on the main wards when possible. The specialist team works closely with the patient and those close to them, the hospital doctors, ward nurses and other allied health professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies to facilitate rapid discharge to patients' preferred place of death.

During this inspection, we spoke with 32 members of staff including members of the specialist team, ward nurses, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain and the bereavement officer, who was part of the patient advice and liaison service (PALS). We spoke with three patients and two relatives. We reviewed six care records and 10 do not attempt cardio pulmonary resuscitation (DNACPR) records. We observed staff interactions with patients and those close to them. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.

We visited most of the medical and surgical wards, the mortuary, the PALS and bereavement office, the chapel and multi-faith rooms and the room for relatives.

# End of life care

## Summary of findings

We rated this service as 'good' because:

- There was an open and transparent culture across the trust, where staff felt comfortable to express their views and approach managers with their concerns. Learning from incidents and complaints were shared across the specialist team and the trust, now that data had been coded in such a way to allow this.
- The environment and equipment in both the hospital wards and the mortuary was suitable for purpose. Infection prevention control (IPC) measures were followed by staff from the mortuary, specialist teams and whilst we observed care on the wards.
- Patient care records and risk assessments were appropriate, thorough and complete. They considered different treatment options and showed clear involvement of patient and relatives in treatment decisions. Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient. Individuals with complex needs were recognised and their care was tailored by the service.
- Capacity and consent issues were well understood by staff and correct procedures were followed in relation to these. Some issues around the completion of do not attempt coronary pulmonary resuscitation (DNACPR) forms had been picked up and were being addressed.
- There were enough specialist nurses on the palliative care team to enable them to see all patients on their caseload. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- A multidisciplinary team approach was evident both across the specialist team and across the hospital. Patients at the end of life were cared for compassionately and holistically, with input from psychology, chaplaincy, physiotherapists and other allied health professionals (AHPs) as necessary. The needs of relatives were also considered and addressed by the wards, specialist team and dedicated bereavement service.

- A recently developed EOLC strategy aimed to ensure that the specialist team were able to support other staff even further in the event of death. A detailed educational strategy was in place and due to be rolled out to ensure staff across the trust felt confident with caring for patients at the end of life. Regular meetings and forums took place that addressed issues in EOLC with various stakeholders. This included a specific EOLC steering group that met quarterly to discuss any issues specific to EOLC.

However:

- Despite the intention to introduce an educational plan, there were some existing issues with staff education and training at the time of the inspection. Ward staff expressed a current need for further training and support around the care of dying patients. Porters were broadly unaware of the procedures to follow in terms of IPC and there were no existing training records for porters at the Royal Brompton site. Despite a recent incident relating to the use of syringe drivers, only 68% of ward nursing staff had been trained in this competency.
- The trust had not fully rolled out a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. The specialist team used the London Cancer Alliance (LCA) principles of care document, but resource files containing this document were not yet available in wards and staff knowledge in this area varied. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.
- Data collection for issues relating to EOLC was currently an issue, limiting the amount of audit activity that the specialist team could take part in and use to improve patient outcomes. The service recognised this as an issue and new data processes were being devised by the IT department to collect information linked to the specialist team's MDT proforma.

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- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This is contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week.
- There was no lay member with responsibility for EOLC on the trust board, although a lay member sat in on the EOLC steering group, which reported directly to the board.

## Are end of life care services safe?

Good



We rated safe as 'good' because:

- There was an open and transparent culture in regards to reporting incidents and learning was shared across the specialist team and trust.
- Infection prevention and control (IPC) measures ensured that the environment was clean and suitable for purpose.
- All equipment was fit for purpose and had been recently serviced.
- Patient care records and risk assessments were appropriate, thorough and complete.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. They were completed by a consultant and recorded detailed discussion and reasoning for decisions.
- Nursing staffing levels in the specialist team were sufficient for staff to perform their roles.

However:

- Porters were broadly unaware of the procedures to follow in terms of IPC and escalation of potential problems in relation to the body store. There were no existing training records for porters at the Royal Brompton site.
- Despite a recent incident relating to the use of syringe drivers, only 68% of ward nursing staff had been trained in this competency.

### Incidents

- Staff in both the specialist team and on the wards were aware of trust wide systems to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. They were able to give examples of when they had used the system to report appropriate incidents. The system had recently been adjusted to highlight any incidents relating to end of life care (EOLC). This enabled feedback and learning points from

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incidents to be shared with staff across the trust via email and team meetings. Incidents relating to EOLC were also routinely discussed in the EOLC steering group, monthly specialist team meetings and senior management meetings.

- The specialist nurses were aware of one recent incident relating to EOLC that had occurred in January 2016. This related to staff competence with the McKinley T34 syringe driver (a device to deliver pain relief medication via a needle or soft cannula under the skin) and a ward nurse not being aware of syringe driver policy or how to locate it. There was a delay in locating a member of staff who was able to find and commence the syringe driver. Although this did not cause a significant delay in providing pain relief to the patient, it raised concerns relating to the competency of staff in using this device as none of the ward staff on shift that morning had undergone any recent training. In response to this incident, staff competency in relation to syringe drivers was added as a concern to the risk register and the need for further training was identified as a priority for both new and established staff.
- A previous incident occurred in August 2015 in which a patient was found unresponsive on floor. Nursing staff carried out CPR as they were unaware of a do not attempt coronary pulmonary resuscitation (DNACPR) order that had been in place for three days prior to the event. Although the patient was not revived, this was classified as a serious incident and a thorough investigation took place. The team met with the relatives of the deceased patient to discuss the incident and a letter of apology was sent, as per duty of candour requirements. Lessons learned included formal communication of DNACPR status at both morning and evening handover and revision of staff break timings during the night to ensure adequate cover of the ward. The investigation report included details of specific meetings where the incident and lessons learned could be shared with staff across the hospital.

## Duty of Candour

- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust had a lead for the duty of candour who was also the lead clinician for clinical risk. We saw examples (such as the incident described above) where the duty of candour regulations were applied correctly.

## Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.
- We found the mortuary and associated areas to be visibly clean and tidy during our inspection. There was a separate operational policy in place to ensure infection control processes were followed in the mortuary and post mortem room. Appropriate clinical waste bins were emptied daily by the mortuary technician, who was responsible for ensuring the entire area complied with IPC standards. We saw records that indicated that the mortuary was cleaned every other day by domestic staff and fridges were deep cleaned every six months.
- Appropriate procedures were followed in the event of death to identify and protect staff from infectious disease. Standard IPC precautions were adopted by staff at all times and thorough risk assessment prior to contact with the deceased was carried out. Death notification paperwork was completed by nursing and medical staff to evidence this, before a body could be removed from the place of death. Copies of these forms accompanied the body to the mortuary and the use of discrete labels to indicate infection was recommended where necessary. We saw evidence that these forms were appropriately filled out and used as stated in the corresponding policy.
- Handwashing facilities and personal protective equipment (PPE) were both available in the mortuary if required. The mortuary technician, who was trained in decontamination procedures, was responsible for any IPC issues that occurred in the mortuary.
- The trust stated that 37 porters across the trust had undergone IPC control training in the last year. Their records indicated that 33 porters were employed across



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both sites at the time of the inspection, with 19 currently in post at the Royal Brompton. However, there were no records on site to indicate that these porters had undergone any form of training at the Royal Brompton site (these were found for the porters at Harefield hospital). Porters that we spoke with were broadly aware of appropriate infection control measures to take in relation to deceased patients, such as the use of PPE when transferring deceased patients. Porters were expected to wipe down the concealment trolley out of hours but this was normally the job of domestic staff.

## Environment and equipment

- The trust used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin). The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations. There was evidence that the syringe driver policy had been amended due to a medical device alert highlighting the risks of prolonged exposure of the devices to direct sunlight.
- Ward staff obtained syringe drivers from the medical engineering department. There were no problems in accessing syringe drivers whenever they were needed for patients as two devices were kept on hospital wards for access out-of-hours. The syringe drivers were requested via a standardised form, according to policy. Any equipment accessed out-of-hours were expected to be replaced the next working day. If patients were discharged home with syringe drivers, they were given prepaid envelopes to return these after community resources had been sourced. The medical engineering department would follow-up these patients to ensure that the syringe drivers were returned.
- The mortuary had capacity for 24 deceased patients from the hospital. The fridges consisted of a number of labelled compartment bays, each containing racks for holding the body trays upon which bodies were stored. Bodies in a range of sizes were able to be stored due to the removable nature of the trays, although bariatric

patients of a larger size could be sent to an undertaker agreed by the service if necessary. There were arrangements with neighbouring undertakers in case of emergencies.

- There was an automated temperature measurement system, and a record of fridge temperatures was kept daily by the mortuary technician. The fridges were linked by alarm to the switchboard for temperature control and 24 hour servicing arrangements were in place in the event of there being a problem. The last occasion that the fridges had encountered an issue was in October 2015. Although the system was reset and the problem resolved, all bodies were transferred to the locally agreed undertakers as an interim measure. In the event of problems occurring out of hours, clear escalation plans were in place.
- All equipment in the mortuary and post mortem room had been recently serviced and labelled to indicate the next review date.

## Medicines

- The trust did not have a specialist pharmacist for palliative care but the team could access advice from specialist pharmacists in other specialist fields, such as pain management.
- In the event of a syringe driver being used, an additional electronic or paper based chart was used to monitor the site and rate of infusion, as well as the battery and maintenance of the device. We saw two charts in use and correctly filled out by nursing staff to optimise patient safety and pain relief. Nursing staff had to undergo a syringe pump competency assessment prior to utilising these devices in practice. Syringe driver training was carried out at the ward level by practice educators. A recent audit showed 68% of nurses had been trained across the trust. Evidence of planned further local training for 80 staff was seen. Syringe driver training was being incorporated into nurse induction training for new staff due to concerns raised in staff competency in this area.
- At present, the trust was developing an in-house audit tool to review anticipatory prescribing to take into account the number of patients that died within the critical care setting. These patients were often ventilated and sedated, altering the nature of anticipatory prescribing. Anticipatory medications were prescribed

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for patients, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required. This prevented delays in symptom and pain relief. The specialist team were usually involved when these medicines were prescribed.

- The trust did not currently audit the use of opioids in palliative care, contrary to NICE Quality Standard CG140.

## Records

- Hospital staff used paper based patient records to record patients' needs and care plans, medical decision making and reviews, and risk assessments. These notes were usually stored appropriately in the nursing office on the wards that we visited. When members of the specialist team were involved in the treatment and care of patients at the end of life, they added an entry to the patient record that detailed the discussions and agreed changes to the care plan. Only medication charts were electronic as standard, although this was being addressed by the trust and a plan was in place to introduce an electronic records system.
- We looked at six sets of patients' records. Information was concise and clear. Conversations with both the patient and family were well documented and detailed. All notes were dated, signed and followed the trust's note writing protocol.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. We reviewed 10 DNACPR forms and all detailed full discussion with patients and their relatives. All forms had been signed by a consultant and all had appropriate reasons for the decision recorded on the form. Only one form did not indicate whether capacity had been assessed.

## Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the trust safeguarding policy on the intranet. Adult safeguarding level 1 was part of the trust annual mandatory training and all staff in the specialist team were up to date. Staff at all levels knew who to contact if they wanted further advice and were able to give examples of safeguarding referrals or concerns that they had raised.

## Mandatory training

- Nursing staff with the specialist team were up to date with all of their mandatory training, according to records provided by the department.
- There were no records available to indicate that porters had any mandatory training this year at the Royal Brompton hospital, including in IPC. Porters we spoke to indicated that issues relating to EOLC had been discussed once at their induction but not since then. Instead, an existing porter would advise a new porter how to care for deceased patients and the issues that may arise around this.

## Assessing and responding to patient risk

- Staff had completed skin integrity assessments to evaluate patients' likelihood of developing pressure ulcers, which are more likely to occur at the end of life due to changes in the body. Patients were regularly repositioned and pressure-relieving aids were used where appropriate to mitigate this risk.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving physiotherapists and mobility aids were put into place.
- Nursing and health care assistant staff monitored all inpatients regularly and used an Early Warning Score (EWS) to identify patients who were deteriorating. Staff on the wards were aware they could access advice and request support from the specialist team if their patient had been identified as requiring palliative support. A 'triggers tool' was available to guide staff in deciding whether or not the patient was entering the last stages of life and should be referred to the team.
- Health care assistants and nurses monitored the comfort of patients who were in the final phase of dying and recorded symptoms in individual nursing notes. Nursing staff reported changes in condition, such as signs of discomfort or agitation, or change in breathing to medical staff.

## Nursing staffing

- The specialist team had at the Royal Brompton hospital had two whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards on weekdays, between the hours of 8.30am and 5pm. There was also a lead nurse and a practice educator who worked across

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both sites. The nursing staff felt that they had enough staff at the present time and would only need an increase in staffing if required to move to seven day working.

- There were no statistics relating to bank or agency use available for the specialist team at the Royal Brompton. The practice educator was able to assume a clinical role to cover any sickness or absence, if the need arose.
- Handovers took place every morning at 8.30am. These were comprehensive and focused on the full holistic needs of each patient, discussing their not only their condition and comorbidities but also their social situation, family and any other complex needs. The nursing team used the handover to plan their visits for the day and anticipate any possible discharges or new referrals.

## Medical staffing

- There was a 0.8 WTE consultant at the Royal Brompton, who was employed as a locum through a service level agreement (SLA) with a neighbouring NHS Trust. Out-of-hours cover was provided by telephone advice from the neighbouring trust's palliative care consultant on call. Any member of the specialist team or ward staff could call the switchboard at the neighbouring trust if they needed consultant support or advice, or handover a list of patients that needed to be seen. The consultant had full access to the caseload in order to offer appropriate advice.
- Staff confirmed that the consultant would usually come on site in the case of an emergency, due to the proximity of the neighbouring trust's site.

## Are end of life care services effective?

Requires improvement



We rated effective as 'requires improvement' because:

- The trust had not fully rolled out a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. The specialist team used the London Cancer Alliance (LCA) principles of care document, but resource files

containing this document were not yet available in wards and staff knowledge in this area varied. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.

- Data collection for issues relating to EOLC was currently limited, restricting the amount of audit activity that the specialist team could take part in and use to improve patient outcomes. The service recognised this as an issue and new data processes were being devised by the IT department to collect information linked to the specialist team's MDT proforma.
- Ward staff expressed the need for further training and supervision around how to support and care for dying patients. An educational plan has been drawn up but not yet rolled out.
- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This is contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week.
- A recent audit of do not attempt cardiopulmonary resuscitation (DNACPR) forms found that only 15% were fully filled out. Another national audit found that DNACPR forms were only in place for 67% of patients, although 89% had been recognised as being in their final phase of life.
- Specific EOLC training had been planned but not rolled out to nursing staff on the wards at the date of our inspection.

However:

- On the whole, care and treatment was provided in line with appropriate national professional guidance.
- Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient.
- A multidisciplinary team approach was in effect both across the specialist team and with the wards and services they worked with.

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- Consent and capacity were considered when patients were making decisions about their preferences at the end of life, as well as in relation to the retention of organs and tissue.

## Evidence-based care and treatment

- Palliative care was managed in accordance with national guidelines, which formed the basis of trust policy. For example, the guidelines for symptom control were based on World Health Organisation (WHO) guidelines for management of pain.
- The trust had not yet developed or introduced specific paperwork in response to the independent review of the Liverpool Care Pathway and had no validated assessment tool for staff to utilise and document that care at the end of life was consistent. The specialist team used the London Cancer Alliance (LCA) principles of care document based on the five priorities of care (One Chance To Get It Right, 2014) to guide their end of life care (EOLC). However, resource files containing this document were not yet available in wards at the Royal Brompton hospital and staff knowledge in this area varied across the wards. Some wards were using their own EOLC plans that included a holistic consideration of the needs and symptoms of the dying patient but this was not used across most clinical areas.

## Pain relief

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. Medical notes showed that the numeric rating scale (NRS) and visual analogue scale (VAS) were most commonly used. Appropriate actions were taken in relation to pain triggers to make patients more comfortable. Staff were encouraged to contact members of the specialist team for advice in complex cases.
- Pain management and symptom control were discussed daily in the specialist team's handover and any queries were feedback to the consultant on call. The specialist nurses visited the wards and regularly reviewed online drug charts and spoke to ward staff about whether patients' pain and symptoms were adequately controlled and managed. Background doses of pain medication were increased where necessary.

- Patients that we spoke with were generally happy that their pain was well controlled. We observed the specialist nurses talking about pain management and symptom control with patients as a matter of course.
- We saw examples in the records of pain control managed with PRN (pro re nata or as required) pain relief. Some patients had syringe drivers, which delivered measured doses of drugs over the course of 24 hours. We saw examples of appropriately prescribed syringe drivers, which nurses checked to make sure they were functioning correctly and that the patient was receiving the correct doses of drugs.
- The specialist nurses worked closely with the dedicated pain management service, who offered advice and support to patients who were experiencing pain because of their treatment or illness. The specialist team had close links with this service and held regular meetings to discuss the management of complex patients.
- We saw evidence that the service strived to meet the needs of those suffering from symptoms in the dying phase of life or because of their illness. The specialist team encouraged the use and regular review of both PRN and regular medication in view of changing symptoms. Complementary therapies were also available to patients to help manage symptoms. For example, patients with a diagnosis of cystic fibrosis had access to reflexology twice per week. There had also recently been a trial into the use of handheld fans to manage breathlessness. The majority of patients had found this helpful and the team planned to purchase more fans for future use. Results from the FAMCARE survey of 15 bereaved relatives in September 2015 showed that 80% of respondents were satisfied with the speed and attention with which their loved ones' symptoms were addressed by staff.

## Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we saw.
- Dietitians attended the weekly specialist multidisciplinary team (MDT) meeting and contributed to discussions regarding appropriate nutrition and

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hydration at the end of life. The speech and language therapists worked closely with the dietitians to establish the food and liquid consistency a patient may require if a patient had difficulty swallowing. Assessments and advice from dietitians and therapists were seen in the notes we examined. For example, some patients were started on dietary supplements because of input from the dietetics team.

- For patients that were not eating at the end stage of life, the ward staff and dietitians ensured regular mouth care was carried out to ensure patient comfort and hydrated the patient via a syringe driver.
- Protected mealtimes were in force, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions.

## Patient outcomes

- The trust carried out some routine audits of the palliative care service, but were currently working on ways to improve data collection as the electronic system was not currently set up to effectively do so. It was recognised that this was key to improving patient outcomes and the trust planned to complete audits in areas such as anticipatory medication prescribing in future.
- In the 'End of Life Care Audit: Dying in Hospital' in 2016, the Royal Brompton did not have enough patients for inclusion in the national data set (10 is the minimum and the hospital only had nine patients suitable for inclusion). However, local feedback on clinical key performance indicators (KPIs) indicated that the hospital scored well in the documentation and discussion of the dying patient, coming above the national average in both measures. Patients who were actively dying also had a holistic individual care plan in 100% of cases, against a national average of 66%. The hospital scored less than the national average in terms of giving patients an opportunity to have their concerns listened to (56% against 84% nationally) and asking patients regarding their needs (44% against 56% nationally). However, seven out of nine patients died in a critical care environment, with six of these patients receiving assisted ventilation. This may have limited the ability of patients to be involved in meaningful discussions. The small size of the data set also makes generalisations difficult.
- The trust identified areas for improvement from this audit around documentation of assessment of the dying patient and formal education for all staff in EOLC. The trust also plans to submit data across both sites for the next national audit to provide more meaningful data. We saw minutes from the April 2016 EOLC steering group that indicated that changes in documentation were being discussed. A detailed education plan had been drawn up that indicated how staff would be trained around specific EOLC topics such as advanced care planning, earlier identification and care of the dying patient.
- Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist team. There were 274 referrals to the specialist team between April 2014 and April 2015. Patients were reviewed within 24 hours of referral or more urgently if clinically indicated; 75% of patients were seen by the team within 24 hours of referral between January and March 2016.
- Any member of staff in the hospital could refer a patient to the specialist team. There was a 'triggers tool' available to ward staff to help them identify when referral may be necessary. This was done either via bleep, during ward visits or in the course of MDT meetings. We observed patients being referred to the specialist team during the course of inspection. Referring staff were encouraged to document the referral in the patient's notes and outline the patient's current clinical problems and reasons for the referral. The referral was discussed with the patient and medical permission was sought from the consultant responsible for the patient's care. The specialist team had a list of patients to be aware of that had not yet reached the threshold for referral. Staff reported that this referral system worked well.
- The management of the dying patient varied across the trust. The majority (59%) of deaths occurred in the critical care environment. In October 2015, the specialist team recognised that referrals from the adult intensive care unit (AICU) were not being properly managed. For example, there was a lack of communication surrounding withdrawal of care between the teams and with relatives of dying patients. An initial meeting was arranged between the specialist team and AICU consultant and matron which explored ways of



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supporting current and future practices to improve integrative working. These included daily review of clinical records of AICU patients referred to the specialist team during handover, increased presence at the AICU multidisciplinary (MDT) meeting and a weekly joint consultant meeting to discuss shared patients. In addition, AICU consultants now bleep the specialist team to invite them to scheduled withdrawals and scheduled family meetings. There are also plans for the palliative care consultant to teach sessions with AICU doctors on 'transition of care from active to palliation' to improve the referral process and facilitate further joint working.

## Competent staff

- There were practice educators on each ward who were responsible for ensuring that staff had sufficient knowledge and skills to undertake their roles safely. Some micro training sessions had been given on subjects relating to end of life care (EOLC), which staff reported they had found useful. The specialist nurses also gave one-off training sessions to staff where needs were identified. Plans were in place to introduce EOLC champions to each ward, who would take a lead in supporting the education of ward staff in areas specific to EOLC. This had already been successfully piloted at Harefield hospital and was due to be rolled out to critical care environments at the Royal Brompton hospital initially.
- Although there had been some in-house training days on subjects relating to EOLC and advanced communication techniques, there was no formal education programme in place for staff at the time of inspection. Most staff felt they could identify patients in the last stages of life and could describe what steps to take in this event, but welcomed the idea of further training in this area. The directorate surveyed twenty-eight staff working with patients with a diagnosis of cystic fibrosis. Of the respondents, 52% indicated they would like further training on EOLC and how to conduct difficult conversations at this stage. Health care assistants also felt they would like more support in this area.
- The trust recognised that education in EOLC was a priority and had drafted a detailed education and training strategy to reflect this. Training on issues relating to EOLC were planned to be part of the

induction for new staff as well as incorporated into annual mandatory training sessions and study days throughout the year. The implementation of this programme was discussed in the last EOLC steering group in April 2016.

- The specialist team was made up of competent and trained staff. They had opportunities to undertake personal development opportunities to enhance their skills and were able to give examples of further study days they had completed. The trust were actively supporting the nursing staff throughout the Nursing and Midwifery Council (NMC) revalidation process.
- The doctors and nurses we spoke with in the specialist team all reported receiving annual appraisals which looked at their development needs and set achievable and realistic targets to measure progress against. We saw records to indicate that this had occurred in all cases where staff had not been just recently employed. The specialist nurses confirmed that they attended monthly clinical supervision sessions and could request more support as and when required.
- Ward nurses, health care assistants and therapists generally indicated that they felt knowledgeable in terms of supporting patients at the end of their lives. They were able to discuss how to care for a patient in their dying phase in terms of physical health and family support, for example. Some staff expressed the need for further specialist training and support around EOLC. A structured education plan was in place to support further staff development in EOLC related topics and ward EOLC champions were due to be rolled out, where a 'train the trainer' approach would be used.
- A recent survey of 28 allied health professionals (AHP) working with patients with a diagnosis of cystic fibrosis indicated that 72% wanted more opportunity to reflect following death of a patient. The MDT planned to develop regular structured reflection for staff to address this.

## Multidisciplinary working

- There was good attendance at the weekly MDT specialist palliative care meetings. One or more specialist nurses attended every meeting along with one of the palliative care consultants and registrars. The chaplaincy team also attended every week, with professionals such as physiotherapists, dieticians,



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pharmacists, social workers- and occupational therapists contributing where appropriate. We observed one such meeting and discussion of each of the patients was holistic and sensitive. A structured and detailed proforma, piloted originally at a neighbouring trust, ensured that specific areas of care were covered for each patient and that each professional had a chance to offer their input. There was clear joint working where each member of the MDT was able to challenge and request further information as necessary.

- A member of the specialist team aimed to attend other MDT ward and speciality meetings, especially on wards where patients were likely to be identified as requiring palliative care, such as the AICU MDT. We attended two such MDTs and found the discussions to be patient-centred, holistic and effective in deciding future plans of shared care between the wards and specialist team. Regular joint meetings were also held with the pain management team and Skype meetings with the transplant and heart specialist nurses occurred on a weekly basis.
- We accompanied two specialist nurses to the wards and saw them actively supporting the work of nursing staff in a constructive and practical way to enhance the care of dying patients. All the staff we spoke with knew the team and said they were visible and readily accessible to give advice and support to staff and patients on EOLC. However, some members of the specialist team felt that their presence in the hospital could be improved by challenging staff perceptions that the specialist team only get involved at the end of the patient journey, when care should be concurrent.
- The care records that we examined confirmed active involvement from health professionals of all disciplines where appropriate, including appropriate referrals to the specialist team. A patient we spoke with confirmed that they had input from a physiotherapist, dietician and psychologist alongside care from the specialist team and their ward. The complex discharge coordinator attended morning bed management meetings and ward multidisciplinary team meetings to identify patients requiring rapid discharges.
- There were service level agreements (SLA) held by the by the Pathology Services Manager to transfer bodies from the Royal Brompton hospital to a designated local

undertaker, should they require post mortem by a coroner. Staff working within pathology and the mortuary confirmed that there were no issues with these transfers and we saw paperwork confirming this.

## Seven-day services

- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. Out-of-hours cover was provided via a SLA by telephone advice from a neighbouring trust's palliative care consultant on call. The consultants had access to the specialist palliative care caseload and received daily handover. Any member of the specialist team or ward staff could call the switchboard at the neighbouring trust if they needed consultant support or advice, or an update on any actions taken out of hours. Ward staff confirmed that they felt comfortable to do so.
- These arrangements were contrary to recommendations made by the 'End of Life Care Audit: Dying in Hospital' in 2016, which specified that face-to-face access to specialist palliative care should be available between the hours of 9am and 5pm, seven days a week. However, only 37% of sites were achieving this nationally.
- The chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service.

## Access to information

- Resource folders relating to EOLC were not yet in place at the Royal Brompton hospital, although they had been piloted at Harefield hospital. The files were compiled and ready to be rolled out alongside the educational programme. There was information available to staff on the bereavement portal on the trust's intranet site, of which ward staff we spoke with were aware.
- One specialist nurse had access to an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they are treated and cared for. A representative from this system planned to attend the next EOLC steering group to discuss the benefits of rolling this system out across the trust. The addition of the database was identified as a specific step in phase two of the trust EOLC strategy.

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## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were clear policy and procedures relating to autopsy examinations and the subsequent retention of organs, to ensure that the trust was compliant with the Human Tissue Act (2004). A booklet entitled, 'The Post Mortem Examination: Information for Relatives' was produced for relatives of deceased patients who required a post mortem. The booklet explained the procedure in appropriate detail and included a form of consent that had to be signed by the relatives. Only the Bereavement Service team were trained to take consent for post mortems. We saw three consent forms for this purpose appropriately and fully filled out with no omissions.
- A small survey of six patients who had received care from the specialist team was completed in April 2016, in which 100% of respondents agreed that their consent had been sought before any procedures or examinations took place.
- Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training was not mandatory. However, there was a policy on the intranet to support staff when considering MCA and DoLS. We saw evidence of capacity assessments in the patient records and saw a discussion between a specialist nurse and occupational therapist about whether a capacity assessment should take place before a patient was discharged home. Other staff were able to give examples of when they had referred patients to clinicians for situation specific capacity assessments. There was a section relating to mental capacity on each do not attempt cardio pulmonary resuscitation (DNACPR) form, which was filled out by the doctor completing it in all but one case (out of 10 forms reviewed).
- An audit of 150 DNACPR forms was completed between January and December 2015. Only 15% of these forms were completely filled out, presenting issues around their validity. Although all forms had an appropriate rationale documented and had been signed or countersigned by a consultant, lack of information relating to discussions with the patient (not completed in 27% of cases) and family (not documented in 66%) were found. However, where discussion with the patient was not possible, 100% of forms documented why this

discussion could not take place. Documentation of why family discussions did not take place only occurred in 40% of cases, which was recognised as requiring improvement. Further training and discussion around DNACPR forms has been planned as a result of this audit, with shared responsibility between the resuscitation department and the specialist palliative team. Spot checks and walk rounds by the resuscitation team were also planned to improve compliance.

- In the 'End of Life Care Audit: Dying in Hospital' in 2016, the Royal Brompton did not have enough patients for inclusion in the national data set (10 is the minimum and the hospital only had nine patients suitable for inclusion). However, local feedback indicated that only six out of nine patients had a DNACPR form in place, although eight had been recognised as being in their final phase of life.

## Are end of life care services caring?

Good



We rated caring as 'good' because:

- Patients were cared for in a caring and compassionate manner by both ward staff and members of the specialist team.
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Staff ensured that patients and their families were informed about their care and were fully involved in any treatment decisions.
- Psychological support for patients was well considered, easily accessible and timely.
- The chaplaincy team offered comprehensive spiritual support to those at the end of their lives.

## Compassionate care

- Staff consistently treated patients with dignity and respect. Nurses and doctors from the specialist team introduced themselves to patients and sought permission to enter their bed space. There were posters around some of the wards that we visited reminding staff to knock before entering side rooms, or ask permission to enter bed spaces. Ward staff drew curtains

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around bed bays when privacy was needed, such as when using a commode. Patients who remained on the ward in their final stages of life were moved to side rooms where possible.

- On some wards, there was limited space between beds in some bays. Nursing staff confirmed that although curtains would always be drawn around beds for privacy, conducting sensitive conversations could be a challenge. In this case, side rooms or day rooms were used wherever possible. A patient confirmed that she always felt treated with dignity and respect despite this limitation.
- Interactions between staff and patients were positive across the hospital. Staff were warm and caring, with a compassionate and sensitive manner. They described caring for patients in their last hours of life, both physically as well as emotionally. When patients had no family, they spent more time with them to make sure they did not die alone. Patients described how the nursing staff were “excellent” and “very responsive”, making sure they were always comfortable and their needs were met. We observed nursing staff taking patients out for fresh air and making sure they were warm and well hydrated. There were examples of health professionals who went that extra mile. A physiotherapist showed us photographs of a same sex wedding that had been organised for a very ill patient in the ward setting. Other patients received pet therapy or had been referred to charities in order to make their dying wishes come true.
- A small survey of six patients who had received care from the specialist team was completed in April 2016. The results were largely positive, with all of the respondents agreeing that they would recommend the service to friends, and five patients agreeing that they had been treated with privacy and dignity at all times. All rated the care received from the team as either ‘excellent’ (five patients) or ‘fair’ (one patient). These findings are supported by the FAMCARE survey from September, where a further 15 bereaved relatives were surveyed. Most relatives (14) were ‘very satisfied’ or ‘satisfied’ with the level of comfort staff provided their loved one and 13 agreed they had been treated with a high level of dignity. Specialist palliative care input had been positive in regards to practical assistance,

response to changes in care needs and management of symptoms throughout the final phase of life. Although both of these surveys used small sample sizes, they were reflected by the findings of our inspection process.

## **Understanding and involvement of patients and those close to them**

- Involvement of, and communication with, patients at the end of life and those close to them was central to the specialist team’s way of working. We saw discussions of family and social circumstances in both handovers and MDTs. In patient records, we saw detailed and thoughtful consideration of patient and family wishes and circumstances. A patient in the high dependency unit (HDU) told us how involved they felt in the planning of their care. They were clear about their terminal prognosis and were always asked their opinion on how best to manage their symptoms or discharge home. A member of nursing staff reflected that it was always important to share information with patients and their families at every stage of the care pathway, as there is an expectation of getting better when you come to the Royal Brompton and it can be difficult to manage expectations without this transparency. We saw this situation managed effectively in practice when a patient suddenly deteriorated. The specialist team and ward staff worked together to support and explain the situation to understandably distressed relatives and reassure them through a difficult time.
- Results from the local survey of six patients in April 2016 indicated that all of these patients had received written or printed information about their condition and that five patients believed this to be the right amount of information. A further five patients felt that the doctor and specialist nurses listened to their concerns, answered questions and involved them in their care. Results from the FAMCARE survey of 15 bereaved relatives in September 2015 reflected this, rating explanations for condition and likely prognosis highly (13) as well as availability to the family (12). A further 12 patients valued the emotional support that the team provided to the family and 13 patients were ‘satisfied’ or ‘very satisfied’ with the way that the family were involved in care decisions.
- Workshops run by a psychologist and specialist nurse had just been introduced specifically for patients living with idiopathic pulmonary fibrosis (a condition in which

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the lungs become scarred and breathing becomes increasingly difficult). This arose from a pilot study to test the feasibility of introducing palliative care as part of a psychological support workshop. These took place every three months and patients' families were encouraged to attend.

- The hospital consultants were always available to meet with all relatives that had lost someone close to them at the hospital, approximately six to eight weeks after death to discuss the patient and their treatment or any concerns.

## Emotional support

- Emotional support for patients was provided by the clinical psychology service, which was made up of psychiatric nurses and a lead consultant psychiatrist. The trust held a service level agreement (SLA) with Central and North West London Foundation Trust to provide this adult psychological service. An additional consultant psychiatrist was employed by the trust to head the liaison psychiatry service, which worked alongside clinical psychology to provide care for inpatients. Psychological support was discussed routinely in MDT meetings and handovers. A psychiatric nurse attended the weekly specialist palliative care meeting. We saw evidence of referrals and sessions that had taken place within care records. One young patient with cystic fibrosis described the weekly psychology sessions she received as 'brilliant'. There were no reported issues with waiting times after referral to the service.
- Staff were aware of the importance of finding out about the spiritual needs of patients and their families and knew how to refer people to the chaplaincy service. There was access to multi-faith chaplaincy, seven days a week through a rota and on-call system. A chaplain (Church of England, Church of Scotland or Catholic) was on site Sunday to Thursday, with an Imam attending the hospital each Thursday in addition to this. Training was given to volunteers and local clergy to provide EOLC to patients so that all faiths were represented in the on-call rota. The team were clearly intuitive, caring and open to anyone who wished to speak with them, whether they had a religious belief or not. They routinely offered informal support to patients receiving palliative care and lent a listening ear. Services were held at Christmas and Easter, as well as prayer meetings on a weekly basis.

## Are end of life care services responsive?

Good



We rated responsive as 'good' because:

- The newly developed EOLC strategy aimed to ensure that services were designed appropriately to meet the needs of local people and the wider population.
- The needs of individuals with differing complex needs were well considered and largely met by the service.
- A dedicated bereavement service offered relatives support and advice to relatives when a patient had died in hospital.
- Staff were aware of the processes to support rapid discharge and a dedicated complex discharge team helped to facilitate this where possible.

However:

- The trust did not currently collect data or audit how many people died in their preferred place of death (PPD). This was one area that the trust planned to begin auditing once methods of data collection had been improved.
- Complaints data relating to EOLC had only recently been coded to allow it to be separated from other departmental complaints. This had previously limited the amount of discussion and learning that could take place in the specialist team in this area.

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

- The trust End of Life Care (EOLC) Strategy was recently developed to reflect the National End of Life Strategy and incorporated national guidance to form its objectives over the course of the next five years (2016 – 2020). The strategy was drafted and revised to take into account various stakeholders, such as the executive board, board of governors, staff, patients, other local providers and Hillingdon Clinical Commissioning Group (CCG). However, the Royal Brompton hospital takes patients from a range of CCGs and geographical areas

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due to the specialist nature of the trust. An EOLC steering group was set up in December 2015 to monitor progress against key goals and outcomes specified in the strategic action plan.

- There were no designated EOLC beds at the Royal Brompton hospital. Ward staff moved patients at the end of life to side rooms whenever possible to provide privacy with their family and friends. Relatives were able to stay overnight to spend time with their loved ones at the end of life.

## Meeting people's individual needs

- Facilities were available for relatives to stay overnight, either in beds on some wards or in specific accommodation. The fee would be waived in the case of bereavement. The canteen was not open overnight but there were kitchen facilities in the accommodation or vending machines within the hospital. One ward sister told us how they gave families food and toiletries, and they had just purchased a coffee machine for patients and their families to use.
- Advance care planning (ACP) varied across the trust. There was currently no formal validated tool to support the introduction of this but it was recognised as a requirement in the EOLC strategy (phase two). One specialist nurse had access to an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they are treated and cared for. A representative from this system planned to attend the next EOLC steering group to discuss the benefits of rolling this system out across the trust.
- The chaplaincy team provided spiritual support for different faiths. The team represented a variety of faith traditions (Church of England, Church of Scotland, Catholic, and Muslim), and were also supported by a number of pastoral volunteers and an out of hours on-call service. The chaplaincy team fostered an extensive network of connections with faith leaders from other religious traditions who visited patients of other religions if required. The service did not currently collect data relating to the number of people of different faiths they visited but reported no issues with providing appropriate spiritual care to patients.
- The hospital chapel did have some Christian symbolism but welcomed people of all or no faiths. There was a separate small Muslim prayer room, separated by screens so men and women could use it at same time. Headscarves and prayer mats were available. The chapel and separate Muslim prayer room were open day and night for prayer or quiet reflection.
- Although the viewing room attached to the body store was neutral in decoration, holy books and prayer books of different faiths were available for families to use on request. Trust policy stated that those responsible for the care and storage of the body should take into account various religious or cultural practices such as involvement in laying out the body, night vigils or providing 'mourners' to sit with the deceased. In such cases, mortuary staff were instructed to make every effort to accommodate such request within security and out-of-hours constraints. Arrangements for release of bodies to funeral directors that needed to be made out of normal working hours (for example, Orthodox Jewish or Muslim burials) were co-ordinated by the Duty Senior Nurse.
- As part of a specialist trust, the Royal Brompton hospital treated patients from all over the country and even internationally. The trust's three largest ethnic minority patient groups at the time of inspection were Indian (7.85%), Pakistani (2.87%) and Other Asian (2.96%). Staff were aware of how to access both telephone interpreting and face-to-face interpreting services, which were requested through a referral form sent via email. We were told that staff try not use families as interpreters as a rule. In urgent or rare situations, staff would request the help of other professionals in the hospital with the required language skills. The patient advice and liaison service (PALS) held electronic copies of all patient information leaflets that could be translated into other languages as requested. Braille or easy read format leaflets were also available on request.
- Patients gave positive feedback about the range and choice of food available. Within the menu there were many options to cater for those with different nutritional requirements. This ranged from high protein and energy foods through to soft fork, mashable and pureed food. Different menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options. Some wards gave patients access to a



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kitchen to prepare their own meals, where appropriate. For those patients that had a nasogastric tube that missed the taste of food, a system called 'taste for comfort' was used to enable the patient to safely feel the texture and flavour of food without ingesting it.

- A dementia champion system had recently been launched at the trust. All patients were screened on admission using a standardised set of questions, some of which related to dementia. Any patients with memory issues identified during their hospital stay were referred to a memory clinic through their GP, as there was no trust geriatrician. There was an electronic flagging system to identify patients living with dementia on the patient administration system. However, not all staff had access to this. Patients living with dementia were offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as possible. Red trays at meal times were used to alert nursing staff the patient may require extra help and finger food was available for these patients. Staff we spoke to had received in-house training on caring for people living with dementia.
- Staff from the specialist team and on the wards were aware of the existence of hospital passports, 'this is me' care plans and the importance of involving families and carers in the care of those with learning difficulties. Patients were often known to staff due to the specialist nature of the service and were allocated to side rooms with sufficient space for their family members to stay overnight if they so wished. We observed a patient with learning difficulties being cared for in a side room that had a timetable stuck to the outside of the door with timings of activities and meetings specified. The team had identified that this patient could get overwhelmed and needed allocated rest times to recuperate. There were pain assessment tools available for ward staff to use for those who had difficulty communicating verbally. Close liaison with the occupational and speech therapy was advised in these cases.
- Emergency psychiatric support was provided by the liaison psychiatry service. The department worked alongside the clinical psychology service to provide support to patients experiencing mental health difficulties. There were no reported issues with the service and staff found it easy to access, with no waiting times from time of referral.

- Ward staff gave relatives a locally produced bereavement pack which included information which covered all the practical tasks following a death in the hospital. There was advice and a checklist guide on registering a death, viewing and funeral arrangements and where to get extra information and support. The bereavement officer we spoke with came from a psychology background and had received in-house bereavement training. Although they felt competent within their role, they hoped to be released for further external bereavement training in the near future. This was difficult because of the small size of the service. In the pack given to bereaved relatives, there was a leaflet entitled "Bereavement support" which signposted some other external agencies that could be accessed for emotional support. It was also noted by the specialist team that a lot of their work involved supporting relatives due to the high number of deaths occurring in critical care environments, where patients could often be sedated or ventilated.

## Access and flow

- In the case of existing comorbidities unrelated to their specialist treatment, patients were referred back to their local district general hospital for treatment. The trust had links with local hospitals. Close working relationships had also been established with local hospices through south west London acute trust hospital consultants, who met on a quarterly basis and support local hospices.
- The trust did not currently audit the number of patients dying in their preferred location as the electronic system was not currently set up to collect data in this way. The service recognised this as an issue and new data processes were being devised by the IT department to collect information linked to the specialist team's MDT proforma. As many patients (59%) died unexpectedly in the critical care environment following complex surgery/treatments, there was no option for them to be transferred elsewhere. The critical care teams were now collecting this information, and an audit was planned later in the year.
- Staff we spoke to were aware of processes relating to rapid discharge to enable patients to die at home or in a hospice. Once a patient's preferred place of death (PPD) was confirmed and a care plan and package had been agreed, this could usually be achieved within 24 hours.



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The hospital had a complex discharge team to coordinate this process who liaised with the specialist team, relevant hospital professionals and primary care services and agreed a plan of care. The complex discharge coordinator attended morning bed management meetings and ward multidisciplinary team (MDT) meetings to identify patients requiring rapid discharges. The trust had its own transport system that enabled the patient to be taken to their preferred place and a person of the patient's choice was able to travel with them. The trust had a service level agreement (SLA) with ambulance transport providers to facilitate rapid discharge. When a patient was discharged to their preferred place of dying, hospital staff gave information to ambulance crews about where to take the person if they died while being transferred. The do not attempt cardiopulmonary resuscitation (DNACPR) form was sent with the patient on discharge to their home or preferred hospice and could be used until a new form was put in place by their GP or doctor taking over their care.

- In practice, some patients were discharged back home or to hospices and we observed multiple discussions around discharge arrangements in handovers and MDT meetings that we attended during the course of inspection. We also witnessed an occupational therapist planning the discharge care package based on a range of functional assessments for a respiratory patient that was nearing end of life. However, due to the nature of the patients treated at the hospital, many deaths occurred in the critical care environment (59%) and so discharge to another location could prove challenging.
- The administrative arrangements relating to death, including liaising with funeral directors, was undertaken by the bereavement office. The bereavement officer liaised with bereaved families to facilitate the removal of bodies from the body stores within a timely period. We were told that this usually occurred within five days if no referral to the coroner was necessary. For those needing to deal with a death out of hours, paperwork was stored on the Bereavement Portal on the trust intranet or in the PALS office. There was clear guidance relating what to do in this case, although we were informed that most death certificates were not issued over the weekend unless in exceptional circumstances.
- Relatives and friends were able to view a body in a room attached to the body store. The public entrance to this

area opened onto a small, but comfortable seating area, which led to the viewing room. A member of nursing staff from the ward where the patient died would escort the family to the viewing room and would remain with them throughout the viewing. The mortuary technician took care in preparing the body for viewing. They were able to describe this process and relate to the escorting nurse any issues that may make viewing the body at the funeral parlour more appropriate. The nurse could then prepare the family the condition of the deceased and what they would see and answer any questions they may have.

## Learning from complaints and concerns

- There were leaflets throughout each ward and department detailing how to access PALS and make a formal complaint, although none of the patients we spoke to had cause to do so.
- Data provided by the trust indicated that there had been no complaints in the last year relating to EOLC. However, the specialist team explained that the system had only recently been coded to allow complaints specifically to EOLC to be separated from other departmental complaints. Complaints were discussed in the EOLC steering group, including one in April 2016 that related to an EOLC patient being discharged home to Dorset. This case was not known to the specialist team members present and so further information was requested from PALS to enable discussion and learning points to be shared. In the trust wide complaints data, there was also a complaint from January 2016 relating a relative who was allowed to stay overnight on Victoria ward when a patient was nearing end of life. They were unhappy with the way a nurse had communicated with them during this time. This resulted in further supervision and human factors training for the nurse in question, and a letter of apology from the matron.
- Learning from local complaints was shared across the organisation through the Governance and Quality committee and the Risk and Safety committee. A quarterly Complaints Working Group (CWG) made up of all professionals involved in investigating complaints also discussed cases where lessons were learned with wider implications which could then be shared across the trust. All staff were invited to quarterly workshops dealing specifically with complaints, where relevant and recurring topics were discussed in depth.

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## Are end of life care services well-led?

Good



We rated well-led as 'good' because:

- The service had recently drafted a clearly defined vision and strategy to improve palliative care provision across the trust.
- Regular meetings and forums took place that addressed issues in EOLC with various stakeholders. The specialist team had a monthly meeting, which fed into the EOLC steering group that met quarterly to discuss any issues specific to EOLC, such as policy changes and procedures. There were also mortality and morbidity meetings every three months.
- Senior staff at all levels were described as supportive and approachable.
- Quality improvement and research projects took place that drove innovation improved the patient experience.

However:

- The hospital failed to meet four organisational KPIs in a national audit published in 2016, including there being no lay member with responsibility for EOLC on the trust board. A lay member currently sat in on the EOLC steering group, which reported directly to the board.
- The data collection methods were not in place to allow effective audits of service wide data until recently.

### Vision and strategy for this service

- The trust had recently developed an EOLC strategy which aimed to ensure those in the last stages of life received safe and individualised care as mandated by the five priorities of care (One Chance To Get It Right, 2014). The strategy also took into consideration the elements of other nationally published documents such as 'Ambitions for Palliative and End of Life Care' (National End of Life Care Programme, 2015) and 'Care of the Dying Adult in the Last Days of Life' (NICE, 2015). The strategy aimed to increase recognition of the dying patient and providing high quality EOLC by 2020. A detailed action plan was drawn up that focused on an education programme led by the specialist team but delivered by practice educators and ward EOLC

champions. Once this was embedded, the specialist team planned to look into ways of delivering further advanced care planning (ACP) and options for community/local support and management at an earlier phase. This would include development of electronic data sharing systems.

- Staff in the specialist team were aware of the aims of the strategy and were able to discuss current developments that would enable targets to be achieved. The hospital were currently in the stage of identifying EOLC champions within the critical care environment to roll out the programme there initially. An EOLC steering group was set up in December 2015 to track the progress of the strategy and ensure that goals and targets were being met.

### Governance, risk management and quality measurement

- Issues relating to EOLC were regularly reported and discussed at the EOLC steering group that was set up in December 2015. The group initially met every two months but now meets every three to discuss issues relating to the EOLC strategy, education, risks, complaints, incidents, establishment and resources, amongst other topics. A monthly meeting of the specialist palliative team fed into this. There was also a monthly mortality and morbidity review group.
- Service leads also met monthly to discuss issues relating to governance of the service within the Rehabilitation and Therapies Directorate. Each service lead could then share any relevant information and feed back to their respective team members. Agenda items included trust wide updates, finances, governance and safety (including review of the risk register), seven day working and individual service updates.
- There were also quarterly unit meetings, through which service wide issues and changes were discussed and shared with a wider group of staff. The trust stated it was mandatory for all staff of band 7 and above to attend, whilst other staff could attend if their clinical caseload permitted.
- We were told by staff that there were two risks relating specifically to EOLC on the current trust risk register. On the version provided by the trust, the only item specific to EOLC was regarding the 'assurance framework' and the risk of staff not knowing who to contact for specialist

# End of life care

advice. This was due to there being a service level agreement (SLA) between the Royal Brompton hospital and a neighbouring NHS trust. However, staff on the specialist team told us that this was now working well and governance arrangements were clear in regards to service provision. The second risk related to syringe driver competency amongst general ward staff. This was currently being addressed by an increased educational programme.

- The specialist team collated some information about their activity, for example the total number of referrals to the specialist team. However, the team were currently working on ways to improve data collection as the electronic system was not currently set up to effectively do so. It was recognised that this was key to improve patient outcomes and the trust planned to complete audits in areas such as anticipatory medication prescribing and preferred place of death (PPD) in the coming year.

## Leadership of service

- The specialist team sat within the Directorate of Rehabilitation and Therapies, which was restructured in 2011 to further utilise multi-professional therapy team working. This was intended to allow greater integration and flexibility between the different disciplines in the directorate. The Directorate was led across both sites by the Director of Rehabilitation & Therapies. Additionally there was a Governance & Safety Lead who facilitates clinical governance, quality and safety for the Directorate. In speaking with both the Director and members of the specialist team, they saw no issues in the governance or leadership structure of the service and believed it to be well placed within the hospital structure.
- In the 'End of Life Care Audit: Dying in Hospital' in 2016 the trust failed to meet four organisational key performance indicators (KPIs). There was not a non-executive director (NED) on the trust board (in common with 51% of hospitals audited nationally) and no dedicated EOLC facilitators (a new KPI as of May 2015, which 59% of hospitals had achieved). There was also no formal in-house EOLC training in communication for medical staff or allied health professionals and no seven day face-to-face service. The specialist team were addressing educational needs through the EOLC strategy action plan. There were no

plans to introduce a NED as a lay member currently sat in on the EOLC steering group, which reported directly to the board. The other KPIs were yet to be considered due to the relatively small size of the service and recent major strategic changes.

- Staff within the specialist team were familiar with the senior team, both locally and at board level. The specialist nurses spoke of how 'wonderful' and approachable their local managers were and felt they could approach them with any issues. The lead nurse shared her time equally across sites and was contactable at all times. The entire team spoke of an open leadership culture with a flattened hierarchy in which everyone's opinion was considered. Senior staff were approachable and visible on the wards.

## Culture within the service

- Many staff we spoke to had worked at the hospital for a number of years and many patients had used the hospital for a long time, due to the specialist nature of the service. Staff commented how proud they felt to work there due to the reputation of the hospital. The specialist team felt they had good working relationships with the ward teams, especially the other specialist nurses in different departments who they worked closely with on a daily basis. No issues were raised in relation to cross-site working with Harefield hospital.
- Staff were able to recall the core Directorate values of 'respect, excellence, helpfulness, accountability and balance' and believed that everyday practice was informed by these.
- Staff were aware of the need to support each other after a death and the specialist team described how they might support ward staff in the event of a difficult bereavement. Some staff, such as AHPs working with young patients suffering from cystic fibrosis, had identified a need for further formal supervision. Of 28 respondents to a survey, 72% wanted more opportunity to reflect following death of a patient. The multidisciplinary team (MDT) planned to develop regular structured reflection for staff to address this.

## Public engagement

- The service invited patient and public involvement through various engagement activities, satisfaction surveys, bereavement days, audits and research

# End of life care

projects. There was a patient representative present at EOLC steering group meetings. The service took informal feedback from patients and improved small aspects of the service, as well as collating results from national surveys or audits such as the most recent FAMCARE audit or 'End of Life Care Audit: Dying in Hospital' audit from 2016. Action plans were in place for patient survey results and improvements that could arise from their outcomes. For example, the specialist service planned to develop a new information leaflet including what to expect when someone is dying as this was recognised as a need.

- Workshops run by a psychologist and specialist nurse had just been introduced specifically for patients living with idiopathic pulmonary fibrosis (a condition in which the lungs become scarred and breathing becomes increasingly difficult). This arose from a pilot study to test the feasibility of introducing palliative care as part of a psychological support workshop. These took place every three months and patients' families were also encouraged to attend.
- The hospital consultants were always available to meet with all relatives that had lost someone close to them at the hospital, approximately six to eight weeks after death to discuss the patient and their treatment or any concerns.

## Staff engagement

- The specialist team actively engaged with staff on the wards and attended various MDT and departmental meetings on a regular basis. This increased the visibility of the team and provided staff across the hospital with easy access to and advice from palliative care services. Ward staff were positive about the knowledge and support they received from the specialist team when caring for dying patients. Some members of the specialist team felt that staff engagement could be better and they could be involved earlier in the patient journey. The EOLC strategy aimed to address this through comprehensive EOLC training for all staff.
- The specialist team lead nurse was working to bring consistency to the EOLC service across both sites. The sites were a considerable distance apart and, therefore, travel between them was time consuming. The lead nurse was working to bring the two sites together by


arranging weekly Skype calls between all the specialist team staff across both sites. Staff were encouraged to speak regularly and swap ideas, ask each other for advice, and support each other when they had experienced a particularly difficult case.

- Staff in the specialist team also attended monthly team meetings, quarterly unit meetings, annual away days and monthly mortality and morbidity meetings. The meetings were designed to foster staff engagement, share information and drive forward improvement. Staff had been consulted on the recently introduced EOLC strategy and changes had been made as a result. For example, greater consideration of paediatric EOLC had been raised as a concern and addressed within the revised strategy and steering group meetings.

## Innovation, improvement and sustainability

- The hospital was part of the London Cancer Alliance (LCA) Palliative Care Group. The lead nurse attended monthly meetings with an aim of supporting and sharing good practice across north-west and south-west London. Additionally, the LCA held quarterly study afternoons which were open to all palliative care professionals, delivering talks and disseminating the work of the LCA group.
- For patients from the local area, close working relationships were established with local hospices through south-west London acute trust hospital consultants, who meet on a quarterly basis and support local hospices and foster joined up working.
- The specialist team had conducted quality improvement projects and audits in areas such as patient experience of use of handheld fans to relieve breathlessness and aprepitant (a medicine used to prevent nausea and vomiting caused by surgery) use in cystic fibrosis. Further detailed audits were planned for the coming year due to the restructuring of the way data was collected and coded. Senior members of the specialist team were involved in ongoing research and spoke at a number of conferences. The specialist nurses had delivered external training to GPs. The team were committed and passionate about improving the service they provided, as demonstrated by the active implementation of the recently instated EOLC strategy.

# Outpatients and diagnostic imaging

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

## Information about the service

Adult outpatient clinics at The Royal Brompton Hospital were held in the main outpatient department located in the Fulham Road site. There were two separate outpatient departments East and West which were separated by a short corridor. There were 11 clinic rooms in each section of the department, 22 in total.

Both wings of the outpatient department had their own reception and waiting areas. A pharmacy was located close to the entrance of the East outpatient department where patients collected their medicines following their outpatient consultation. The x-ray department was adjacent to the West outpatient department and there was phlebotomy rooms close by where patients had blood tests.

There were 243,663 outpatient attendances at the Royal Brompton hospital site. The majority of attendances, 75%, were follow up appointments, 5% were first appointments. The proportion of follow up attendances was higher than the national average of 55%. Many patients had visited the hospital as an outpatient over several years.

There were four MRI scanners, two CT scanners, three Gamma cameras, four X-Ray Rooms and comprehensive non-invasive cardiac, lung function and sleep laboratories. A single laboratory medicine service operates from both sites.

The diagnostic imaging service comprised routine X-ray service, Mobile X-ray service, CT scanning, MRI scanning, CMR scanning (Specialised chest MRI, Ultra sound and Fluoroscopy

There was a patient transport waiting area for patients who required transport home.

During the inspection we spoke with five Consultants, six nurses and five radiographers. We reviewed 10 sets of patient records and spoke to a total of 15 patients and relatives.



# Outpatients and diagnostic imaging

## Summary of findings

We rated the service overall as Good because:

- There was a strong culture of reporting and learning from incidents. Incidents were discussed at staff meetings and clinical governance training events. Action was taken to reduce the likelihood of similar incidents occurring in the future.
- The number of (IRMER) incidents reported was higher in 2015 than the previous year. This had been investigated and improved reporting was demonstrated to be the main reason for the increase.
- An audit of hand hygiene practice was performed by the modern matron or senior nurse at least once per month in the outpatient clinical areas. Results were collated by the infection prevention and control team. The audit recorded at least 20 hand hygiene opportunities against observed practice before touching a patient, before performing a clean or invasive procedure, after handling body fluids, after touching the patient, environment, or objects involved in the patients' care.
- Equipment in diagnostic imaging was well maintained with rolling programmes of servicing and checks.
- Hand hygiene audits in diagnostic imaging departments showed high levels of compliance
- Medicines were stored safely and patients were able to collect their prescriptions after their appointment from the pharmacy adjacent to the outpatient department.
- Clinical support assistants were trained and supervised by registered nurses to carry out a range of tests in advance of patients seeing their consultant.
- The outpatient and diagnostic imaging departments provided an effective service based on national good practice guidance and evidence based guidelines.
- There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions that had a positive impact on outcomes for patients.
- Clinical support staff were trained and supervised by registered nurses to provide a range of patients' tests so that the results were available for the patients appointment with their consultant.
- Staff were competent and supported to provide a good quality service to patients. Staff were skilled in their specialist area and were supported in their roles by ongoing specialist training and development opportunities.
- There were effective multi-disciplinary teams in place within the hospital and links with specialists from other trusts.
- Audits were carried out in CT and other diagnostic imaging services which reviewed practice against guidelines and set goals for improvement
- All the patients we spoke with told us they felt as if they were treated as individuals. Many patients had visited the hospital regularly for several years and told us they knew staff well and always felt supported.
- Services supported patients to self-manage their care where possible helping them to retain their independence and reduce the number of times they had to travel to the hospital.
- Staff considered patient's personal circumstances when organising care and organised counselling to support patients.
- Patients emotional and psychological needs were assessed as part of the treatment process.
- Patients told us they received instructions with their appointment letters and were given written information as needed.
- Appointments between outpatients and diagnostics were co-ordinated to allow patients to have diagnostic procedures whilst waiting for consultation minimising the time that patients spent in hospital.
- Staff described how patients in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required.



# Outpatients and diagnostic imaging

- Long term patients were given an emergency number to contact if they needed to be seen urgently and could be seen on weekends on the ward by medical cover staff.
- Radiology had slots available to urgently accommodate patients travelling long distances avoiding them making multiple journeys.
- The trust met the national standard for referral to treatment rates each month for non-admitted pathways between April 2015 and March 2016 with the exception of October 2015.
- The trust consistently exceeded the target for cancer patients to be seen by a specialist within two weeks of urgent GP referral between quarter 3 of 2013/14 and quarter 2 of 2015/16 apart from March - June of 2014/15 and to receive first definitive treatment within 31 days of diagnosis.
- The percentage of diagnostic waiting times over six weeks was consistently lower than the England average between October 2013 and January 2016 with the exception of July 2015.
- There were clear governance and risk management processes in place.
- Staff in diagnostic imaging felt they contributed to improvements at work.
- The results of the 2015 staff opinion survey by staff group showed radiology scores for staff engagement were higher for radiology staff than many other clinical teams in the trust.
- Staff in outpatients and diagnostic imaging spoke highly of the trust's leadership who were visible throughout the Royal Brompton departments.

However,

- We were told the service did not record the time patients arrived in clinic, so waiting times were not routinely monitored. The nursing team were responsible for informing patients if there was a delay.
- The trust consistently breached the target for patients to wait less than 62 days from urgent GP

referral to starting treatment between quarter 3 of 2013/14 and quarter 2 of 2015/16. The trust was working with referring trusts to improve pathways and referral times.

- The Brompton Heart Division risk register highlighted that patients with congenital heart disease had to wait for longer than 12 months to be seen in the adult congenital heart disease clinics. The service was unable to see patients who had been referred. Patients often became unwell before they could be seen in clinic and there were problems reviewing follow up patients who had received their surgery. The trust reviewed the list of patients waiting to be seen and were providing additional capacity to reduce the length of time patients waited.
- Figures provided by the trust showed 27% of clinics started late for the period April 2015-March 2016. The trust were aware of the problem and were working on reducing the number of clinics which started late.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated safety as good because:

- There was a strong culture of reporting and learning from incidents. Incidents were discussed at staff meetings and clinical governance training events. Action was taken to reduce the likelihood of similar incidents occurring in the future.
- The number of IRMER incidents reported were higher in 2015 than the previous year. These had been investigated and improved reporting was the main reason for the increase.
- Equipment in diagnostic imaging was well maintained with rolling programmes of servicing and checks.
- Hand hygiene audits in diagnostic imaging departments showed high levels of compliance.
- Medicines were stored safely and patients were able to collect their prescriptions after their appointment from the pharmacy adjacent to the outpatient department.
- Clinical support assistants were trained and supervised by registered nurses to carry out a range of tests in advance of patients seeing their consultant.

However,

- Alcohol gels were available for staff and patients to use for hand hygiene but we did not see any posters encouraging their use or reminding patients about the importance of minimising infection risks.
- Requests for CT scans were made using the trusts electronic referral system and on hand written request forms. This led to delays on some occasions whilst radiography staff checked hand written information.

### Incidents

- There were 189 incidents within the diagnostic imaging service between June 2015 and June 2016 ranging from 23 in July 2015 to eight in February 2016.
- One member of staff told us about an incident where the wrong letter was incorrectly filed in a set of patient

notes which resulted in an omission. Staff had been reminded of the importance of correctly identifying patients and ensuring information was correctly filed in patients' notes.

- We saw an analysis of incidents which had taken place in the nuclear medicine department. There had been three incidents between July 2015 and January 2016. These related to issues with the equipment stored on the resuscitation trolley, flooding in the department and the use of an incorrect tracer for a patient undergoing ventilation and perfusion lung scanning. It was not clear how serious the patient related incident was or what action the service had taken to reduce the possibility of a similar incident occurring again.
- We saw a report which had been produced for the radiation protection committee in March 2016 reviewing a number of safety issues such as incidents, including high dose reports and contamination incidents. There had been one contamination incident in 2015-2016 which was less than previous years.
- We also saw the results of contamination monitoring audits carried out in 2015 in nuclear medicine which showed a small number of environmental monitoring omissions and staff monitoring had improved. Personal contamination was found on three occasions, two cases had the appropriate actions recorded and the remaining one had been appropriately dealt with.
- There were 101 incidents reported in radiology in 2015 compared with 77 in 2014. 72 of the incidents were patient related the other 29 were non patient related. Two incidents resulted in a moderate harm but did not result in permanent harm. Incident forms were reviewed by the quality department who found managers had always completed the lessons learned section. None of the incidents in 2015 were IRMER reported.
- Incidents were discussed at monthly imaging staff meetings to help learn and make changes reducing the likelihood of similar incidents occurring again. The department had carried out an audit of chest drain removals following a review of reported incidents.
- There had been two IRMER reportable incidents in the last 12 months. One patient had been wrongly referred for a scan in March 2015 and one patient had been recalled for a repeat CTA scan in April 2015 due to poor contrast in the first scan.

# Outpatients and diagnostic imaging

- Regular audits of radiation protection facilities were carried out as part of the services provided by the Radiation Protection Adviser to ensure compliance with ionising radiation requirements (IRR) 1999.
- Departmental audits in the X-ray and CT departments took place on 25 February and 10 March 2016. There was good compliance but some areas required improvement for example paper CT requests were on occasion filled in by one person and signed by another.
- In 2015 there were 16 patient exposures greater than intended (10 in 2014). Eight were reportable as an incident under IR(ME)R 2000. This compared with four in 2014. The increase in 2015 was significant. A report to the Radiation Protection Committee suggested this could be due to improved reporting, rather than an actual rise in radiation incidents. Staff had received an IRMER update in a clinical governance event.
- Clinical support staff were trained to use the incident reporting system. Minutes of the Quality and Safety committee showed incidents were discussed and lessons learned were shared in the meeting and disseminated more widely throughout the division.
- There had been no 'Never Events' reported between March 2014 and February 2016. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There were clinical governance days where staff discussed complaints and incidents and some training.

## Cleanliness, infection control and hygiene

- Overall we found the outpatient department and diagnostic and imaging services were compliant with the "Code of Practice on the prevention and control of infections and related guidance" issued by the Department of Health in 2010.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Alcohol gels were available in the outpatient department. Containers were located on reception desks and were fixed to the wall in clinic rooms. We observed staff using personal protective

clothing (PPE) and routinely using hand gels when they entered and left patient treatment areas. We did not see posters displayed prominently reminding staff and visitors to use the gels.

- We saw clinic rooms had spillage kits. Staff told us they had received training in how to use the spillage kits.
- An audit of hand hygiene practice was performed by the modern matron or senior nurse at least once per month in the outpatient clinical areas. Results were collated by the infection prevention and control team. The audit recorded at least 20 hand hygiene opportunities against observed practice before touching a patient, before performing a clean or invasive procedure, after handling body fluids, after touching the patient, environment, or objects involved in the patients' care.
- One patient told us the clinic was always very clean. They said staff always used gels when they finished examining them.

## Environment and equipment

- Endoscopy procedures were performed in the outpatient department. Staff explained how they cleaned the equipment in the department. Staff followed a standard operating procedure which had been developed.
- We observed that there was not a quiet room for staff to have sensitive discussions with service users. Staff explained to us that there was pressure on the availability of clinic rooms due to the age of the building. The trust told us they acknowledged the benefit of a designated quiet room, clinic co-ordinators identified space to conduct sensitive discussions with patients when required.
- We spoke with three consultants who told us one of the main challenges in the outpatient department was the shortage of suitable clinic space. They said managers were aware of the problems and there were plans in place to develop a new department. The trust told us they reviewed the use of the outpatient department and whether the service could be further supported for example, by virtual clinic sessions.
- There was access to oxygen cylinders in the outpatient department with renewal dates into 2019.

# Outpatients and diagnostic imaging

- Equipment in diagnostic imaging departments was checked monthly. There was a rota for radiography staff to check equipment. Not all the equipment had safety checks dates displayed. Radiography staff were aware of the arrangements in place for obtaining engineering support for major pieces of equipment for example the CT scanners. We saw the telephone numbers of the contractors were on display in the office.
- We saw a register for servicing x-ray equipment held on the trust's IT system with records of equipment checks and servicing dates.
- Radiology equipment was checked in the morning before clinics began. We saw records of checks which had been carried out.
- Equipment in diagnostic imaging was checked on a rolling maintenance programme. We saw equipment maintenance schedules which showed equipment checks were up to date and complete. Staff within diagnostic imaging departments undertook quality control checks including calibrating equipment. We saw quality control and calibration protocols for example in the lung function unit.
- There was one emergency resuscitation trolley which was located between the two outpatient clinic areas. We asked managers if they were sure staff could access the trolley quickly enough in an emergency and they told us it had never been an issue. We saw records which showed the crash trolley was checked every day.

## Medicines

- Patients received prescriptions in clinic for medicines to take home. Patients were able to take their prescription to the pharmacy located at the entrance to the outpatient clinic. The prescriptions could only be issued by the hospital pharmacy. Staff told us they provided prescription pads to consultants when they arrived in clinic and removed them at the end of the clinic. The prescription pads were stored in a locked cupboard when not being used.
- The length of time patients waited to have their prescriptions dispensed was monitored by the pharmacy department. We saw the monthly results for 2015 and the first two months of 2016. These showed

the average waiting time was 33 minutes. The average waiting time was longest in January 2016 when patients waited for 38 minutes. The shortest average waiting time was 27 minutes.

- There were no controlled drugs or chemotherapy drugs stored or used in the outpatient department.
- Medicines were stored in locked cupboards and the nurse in charge held the keys. Lockable fridges were available for those drugs needing refrigeration and fridge temperatures were recorded daily during normal working hours.
- The pharmacy provided an emergency supply service on Saturdays from 9am-2.30pm. Pharmacists visited the wards providing a pick up service for urgent items. They also dispensed urgently needed in patient items, medicines for discharge and replenished the emergency drug cupboard, supply controlled drugs and, supply stock items. There was no on-site service on a Sunday. An on call pharmacy advice service and provided an on-site service in an emergency.

## Records

- The CT service received electronic and hand written referrals. The trust had an electronic referral and record system to improve access to and the quality of clinical information but not all staff were using the system. We asked staff about receiving both electronic and paper referrals and they told us this led to confusion and the risk of referrals not being processed effectively. The trust told us 55% of all CT scan requests were made electronically between January and June 2016. They said they sometimes had to ask referrers to clarify or confirm their hand written referral before proceeding resulting in delays to patients being treated. They said the electronic referral system had been designed to provide transparency and traceability. Managers told us they were planning to ensure the electronic system was used consistently across the service.
- We saw results from the national audit of percutaneous coronary interventions that demonstrated there were high levels of data completeness. Over 90% for all the records submitted to the audit showed good standards of record keeping.
- One member of staff told us about an incident where the wrong letter was incorrectly filed in a set of patient

# Outpatients and diagnostic imaging

notes which resulted in an omission. Staff had been reminded of the importance of correctly identifying patients and ensuring information was correctly filed in patients notes.

- We reviewed 10 sets of patient records which contained risk assessments such as breathing difficulties. Patients were assessed using a nationally developed asthma assessment questionnaire.
- Two consultants told us there was no problem getting access to patient test results and no problems with missing notes.
- Notes were tracked electronically. If a patients' notes could not be found outpatient department staff would create a set of temporary notes and retrieve all previous clinic consultation letters and supporting information into the file.
- Outpatient administration staff checked patient records against the next day's clinic list to ensure that all records were supplied.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. The staff training spreadsheet recorded that 100% of staff were up to date and had completed mandatory training in information governance.

## Safeguarding

- Staff told us they had all received safeguarding training as part of their mandatory training. Although the clinics were mostly for adult patients some clinics were provided for families for conditions which were inherited. Staff were aware of the different types of abuse and told us they would report any concerns to their line manager.
- Information provided by the trust showed; 100% compliance safeguarding adults level 1 and safeguarding children level 1 for nursing and other clinical staff.
- Safeguarding adults training at level 2 was not required as all managers in the OPD were non clinical.
- 50% nursing staff had received safeguarding children level 2 training.

- A new organisational structure had recently been introduced for the safeguarding service managed as part of the rehabilitation and therapies directorate. Safeguarding staff routinely attended clinical multidisciplinary team meetings (MDT) and provided support and training for staff in the outpatient and diagnostic imaging departments.

## Mandatory training

- There were high levels of compliance for mandatory training. Mandatory training included: fire safety (100% compliance for nursing and other clinical staff); health and safety (100% compliance for nursing and other clinical staff); moving and handling (100% compliance for nursing and other clinical staff); infection control (100% compliance for nursing and other clinical staff); medicines management (100% compliance for nursing and other clinical staff); equality and diversity (50% compliance for nursing and 100% for other clinical staff).
- Prevent training was recently added to the mandatory training so compliance rates were lower (50% compliance for nursing and 0% other clinical staff) as staff had not yet had an opportunity to undertake the training.
- Training for staff in basic life support was mandatory in the outpatient department, this included staff working on the department's reception desk. 100% of staff had completed basic life support training.

## Assessing and responding to patient risk

- There were protocols in place if a patient became unwell in the outpatient department. Staff arranged for patients to be transferred to another trust which accepted emergency patients.
- Interventional radiology used an adapted version of the World Health Organisation (WHO) checklist. The WHO checklist is a process for checking the identity of the patient and the procedure before during and after interventional procedures took place.
- Clinical support staff were all aware of the importance of correctly identifying patients using name date of birth, address, GP and referring hospital. We observed two members of staff explaining to patients the importance of checking their identity before they took a blood sample.



# Outpatients and diagnostic imaging

- There had been incidents where patients were incorrectly identified. Following investigation it was found that incorrect patient identification information had been entered on to hospital computer system. This had been included in the local risk register for diagnostic imaging services. To reduce the risk of a patient being wrongly identified staff were encouraged to have a positive confirmation of the patients ID (Name and DOB) checked against the patient's wristband.
- Diagnostic imaging staff had identified the risk of missing unexpected findings. To address this a system had been put in place to notify referring consultants if anything unexpected was found on a patient image.
- Patients with asthma had been assessed using an asthma control questionnaire (ACQ7) which identified if they were woken by their condition and the extent to which their ability to carry out daily activities was affected.
- The trust employed patient navigators whose role was to ensure patients on a pathway received the appropriate care.
- Nursing services in the outpatient department were provided by the outpatient nurses and clinical nurse specialists (CNSs). For example, allergy, heart failure, angioplasty (procedure unblocking blood vessels or coronary arteries), and tissue viability (TV).
- There were 4.93 Whole Time Equivalent nursing staff in post at The Royal Brompton outpatient imaging department, against a planned establishment of 4.9 WTE.
- There were 49.06 WTE other clinical staff in post at The Royal Brompton outpatient imaging department, against a planned establishment of 50.82.
- Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. A safe staffing dashboard was displayed in the outpatient department. This showed details of the required levels of staffing, and actual levels present on each day. Staffing levels were adequate, as was the required skill mix at the time of our visit. An online acuity tool was used to assess the required staffing levels for each day.

## Equipment and Environment

- The outpatient department was located on the Fulham Road site. The number of clinic rooms and the size of the clinic rooms was limited. Some services were unable to fully provide the service they had planned to deliver because of a lack of clinic space. There were 22 consulting rooms.
- Managers told us there were plans to relocate the whole outpatient department to provide new, purpose built facilities.
- Equipment within the department had been tested for electrical safety.
- Equipment was stored within store rooms, some x-ray equipment was inappropriately stored on corridors ready for use.
- We examined the resuscitation trolley located between the East and West departments. The two departments shared one resuscitation trolley. When we asked staff about this they said this had never presented a problem. The equipment inside the trolley and the defibrillator was appropriate and had been checked daily.
- There was a bank for nursing staff so the hospital had cover for staff sickness and holidays. Bank staff had an induction and mandatory training was provided. Many of the bank staff had worked at the hospital before and were familiar with the trust's processes.
- We spoke with three clinical support assistants. They supported nursing and medical staff in clinic. They rotated through the west and east departments. There were six clinical support assistants (CSAs) and two registered nurses in the East section of the outpatient department. There were two registered nurses and five clinical support assistants in the west section of the outpatient department.

## Medical staffing

- Medical led clinics had a sufficient number of medical staff to support outpatient clinics. Consultant teams from the clinical divisions provided medical input to the clinics. The outpatient department did not employ a separate group of doctors to see patients. This meant medical staff from clinical teams could see the patient

## Nursing staffing



# Outpatients and diagnostic imaging

and organise tests and investigations before organising surgery or other treatment getting to know the patient, discussing the options and explaining what would be involved with their agreed treatment plan.

- Consultant radiologists were present on site between 9am and 6pm, Monday to Friday. On call and ward cover outside of these time was provided by a first on call Specialist Registrar, with cover by a consultant radiologist, who was off-site but with remote access to images, and available to attend on site if required. There was a local collaborative agreement in place so that a radiology consultant was available to cover any out of hours interventional procedures that may be required.
- We saw a peer review report of the diagnostic imaging service completed in 2014 which stated the Brompton hospital had no substantive appointments for 20 years. The report recommended carrying out a job plan review to ensure radiology provision was optimised cross-site, utilising existing workforce to expand the number and competency of the consultant workforce and in particular to appoint a congenital and advanced cardiac focussed cardiothoracic radiologist.

## Diagnostic imaging staffing

- There were 22 permanent staff, one agency staff. Two staff were on maternity leave and one was on long term sick leave. The imaging manager said there were no staff shortages and all posts were filled. Some staff worked part time. There were also four radiographers in the CT department. Radiographers worked from 8.30 am to 4.30pm or 10am to 6pm
- Consultant radiologists were present on site from Monday to Friday between the hours of 9am and 6pm. On call and ward cover outside of these time was provided by a specialist registrar, with cover by a consultant radiologist, who was off-site but with remote access to images, and available to attend on site if required. There was a local collaborative agreement in place to ensure a consultant radiologist was available to attend out of hours interventional procedures.
- A peer review report of diagnostic imaging recommended a review of the roles of radiography staff to look at opportunities for skill mix and higher training for example to expand the insertion of peripheral venous access devices by radiographers.

## Major incident awareness and training

- Staff told us they had been involved in a rehearsal of the trust's major incident plan. They said some staff had played roles to test the effectiveness of the plan.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The service was not rated for effectiveness but we found:

- The outpatient and diagnostic imaging departments provided an effective service based on national good practice guidance and evidence based guidelines.
- There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions that had a positive impact on outcomes for patients.
- Clinical support staff were trained and supervised by registered nurses to provide a range of patient tests so that the results were available for the patients consultation with their consultant.
- Staff were competent and supported to provide a good quality service to patients. Staff were skilled in their specialist area and were supported in their roles by ongoing specialist training and development opportunities.
- There were effective multidisciplinary teams in place within the trust and with specialists from other trusts.
- Audits were carried out in CT and other diagnostic imaging services which reviewed practice against guidelines and sets goals for improvement.

However,

- Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not mandatory in the trust, which meant staff were at risk of not complying with the Mental Capacity Act code of practice 2007 in regards to patients lacking capacity consent to care and treatment. The trust told us there were monthly training sessions open to all staff where

# Outpatients and diagnostic imaging

MCA and DoLs was covered. MCA and DoLs training was also provided as part of consent to treatment training. Staff had access to the trust's policies on the trust's intranet.

- Not all staff joining the trust received a timely induction, some had to wait several months.

## Evidence-based care and treatment

- The trust participated in the National Cardiac Benchmarking Collaborative (NCBC). This is a UK-wide collaborative of specialist cardiac centres to enable centres to benchmark and compare the services they provide against their peers, in order to help improve quality and efficiency.
  - Optimisation of medical exposures is required under regulation 7 of IR(ME)R 2000. In 2015 DRPG were involved in three optimisation projects: These were for adult and paediatric cardiothoracic CT scans, adult and paediatric respiratory CT scans and paediatric brain CT scans
  - Policies and guidelines used by the service incorporated National Institute for Health and Care Excellence (NICE) guidance.
  - We saw the trust's policy for ensuring accidental or unintentional exposures to ionising radiation were reduced as far as practicably possible. The policy was up to date. It had been reviewed in December 2015 and was valid for two years.
- ## Pain relief
- Staff were able access appropriate pain relief for patients within clinics and diagnostic settings.
  - We saw records of pain assessments as part of patients' records.
- ## Patient outcomes
- We saw the results of audits designed to review the care provided and make improvements. For example, an audit in January 2016 reviewed the diagnosis and treatment of patients with a pulmonary embolism by the CT department.
  - The diagnostic imaging service followed the Royal College of Radiologists standards and safety checklist for radiological interventions. The standards were based on the World Health Organisation (WHO) surgical interventions checklist adapted for use in a radiology department. An audit of pleural drainage safety which took place from April to October 2015 reviewed 25 sets of patients records. The audit found the checklists were not always being completed on the system. Staff were reminded of the evidence that the checklist resulted in improved patient safety. The service planned a further audit in six months to assess if compliance with the guidelines had improved.
- Medical staff completed an outpatient consultation form which patients returned to the reception desk. These recorded the outcome of the clinic visit for example whether further tests were required, if the patient was being discharged or when the patient required a follow up appointment. Reception staff used these to organise patient's future care.
  - The trust informed us they participate in: BSCI (British Society of Cardiovascular Imaging) - Radiation dose audit of computed tomography coronary angiography; DH Clinical Outcomes and Services Dataset for Lung Cancer (previously called LUCADA); National Cardiac Benchmarking Collaborative (NCBC) and IPEM Evaluation of Half-activity Myocardial Perfusion Imaging.
  - The pharmacy service had reviewed compliance with the (NICE) guideline on medicines optimisation, which contained recommendations for systems to identify, report and learn from medicines related patient safety incidents. The audit took place from December 2015 to March 2016. A total of 977 interventions were recorded across both the Brompton and Harefield sites. The audit found choice of drug was the most significant issue (22%), followed by need for a drug (18%) and medicines reconciliation discrepancy or omission (16%). A high proportion of the interventions were accepted by prescribers, 869 (89%), 71 (7%) were for advice/information only, 22 (2%) were not accepted and for 15 (2%) no change was required. Results demonstrated 537 (55%) of the interventions were of low/minor significance, 302 (31%) of moderate significance and 24 (2%) were of severe/major significance. The audit concluded that clinical guidelines were the main source of support for staff clinical staff when prescribing antimicrobials and antiplatelet medicine. Staff were encouraged to use the guidelines on the trust's intranet.
- ## Competent staff

# Outpatients and diagnostic imaging

- Staff received annual appraisals. Information provided by the trust showed outpatient and diagnostic imaging appraisal rates of 96% at The Royal Brompton site.
- Competency assessments were in place for outpatients and diagnostics and induction processes were in place for new staff.
- We spoke with one registered nurse who worked for an agency who told us they had received an induction when they first started working for the trust. We saw the guidance notes they used for organising clinics. These were compiled by staff working in the clinic. They identified what tests or investigations and equipment were required for each clinic.
- Clinical support staff were all up to date with mandatory training and had received an appraisal within the last year. They were able to access and show us their training records on the trust's IT system.
- We spoke to phlebotomy staff that had recently joined the trust. One had been in post for several months but had not had an induction another had waited three months for their induction. They told us the trust waited until there was a group of staff who required induction before organising a course. The trust told us there had only been two new members of staff joining the outpatient department and one received their induction the month they started the other had waited for six weeks. All new staff including bank and agency staff completed local induction within five working days of starting work in the department.
- Staff in nuclear medicine were involved in five multidisciplinary team meetings to plan the care patients received.
- Specialist nurses who cared for patients with cystic fibrosis described the MDT arrangements for patients with cystic fibrosis. The team met every Wednesday to discuss patients they had been in contact with. They knew their patients well and were able to advise them based on the discussion held at the MDT.
- When we visited the nuclear medicine department staff told us one of the largest components of their workload was cardiac imaging. The service was provided by a multidisciplinary team which included medical staff from cardiology and nuclear medicine, specialist nurses, radiographers and technologists. The service worked closely with a neighbouring NHS trust to provide their patients with PET CT scanning.
- The outpatient Service at the Brompton Hospital Fulham Wing provided 2 Week Wait suspected cancer pathways and AF (Atrial Fibrillation) Rapid Access.
- Nursing staff told us medical staff were very well organised and worked well together as a team.
- Many of the clinical services provided were delivered by multidisciplinary teams, e.g. transplantation outpatients, CF, heart failure, arrhythmias. The trust considered MDT meetings as an integral part of the clinical evaluation and decision making. The trust told us output from MDT meetings was produced and recorded in the patient records.
- The trust confirmed they had not formally evaluated the effectiveness of individual MDTs, however a number of independent external reports had cited the multidisciplinary working in the trust as examples of good practice. The Cystic Fibrosis Trust recently highlighted 'the world-leading paediatric academic and research track record and the excellent clinical care with a holistic/MDT-centred approach, as well as the accessibility of the staff to shared-care teams', as areas of good practice.

## Multidisciplinary working

- We saw examples of multidisciplinary team (MDT) discussions involving medical and diagnostic imaging staff discuss and plan investigations and care plans.
- There were joint clinics with specialists from other trusts for example there was a joint adult cystic fibrosis and endocrinology clinic at Royal Brompton Hospital once a month involving endocrinology and diabetes specialists from a neighbouring trust. A service agreement was in place to access obstetrics and gynaecology, gastroenterology, orthopaedics, ophthalmology, urology and psychiatry specialists based at another trust.

## Seven-day services

- Outpatient clinics operated from 9am to 5pm Monday to Friday. There were no regular weekend clinic appointments in the outpatient department.

# Outpatients and diagnostic imaging

- The diagnostic and imaging departments provided services such as blood tests and x-rays at the weekend; an x-ray technician was on-call out of hours (OOH) seven days a week. CT scanning and catheter lab provided a 24 hour on call service seven days a week.

## Access to information

- Diagnostic results were recorded on patients' electronic records, giving staff across the trust immediate and up to date access to patients' records.
- The radiology department used a nationally recognised system to report and store patient images. The imaging department's picture archiving and communication system (PACS) allowed access to all imaging from anywhere within the trust.
- Previous images could be viewed by staff. There was same day imaging with CT-scans, a system that makes use of multiple x-ray images; echocardiograph (ECHO), and a system that creates ultrasound images of the heart; and x-rays. This meant patients' images could be viewed on the day they attended clinics.
- The risk register for diagnostic imaging highlighted problems accessing historical images which were archived on the system and there were sometimes delays which meant radiologists might not be able to compare recent and historical images. The retrieval system was being upgraded. To reduce the risk a protocol was in place for requesting image retrieval with specialist staff who knew the system locating the images.
- Records contained copies of letters which had been sent to patients and copied to their GPs following their appointment.
- Patients were given test results in a timely way. A patient told us they were provided with a results sheet to take to their General Practitioner (GP).

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. This meant staff worked on an implicit assumption that people had attended their appointments and therefore consented to their care and treatment.

- If written consent was required for more complex procedures this was obtained in outpatient clinic by medical staff.
- Staff in the outpatient department were familiar with the need for mental capacity assessments and best interest decisions if the patient had a condition which meant they were unable to consent to treatment.
- The records we reviewed showed the consent forms contained a section for identifying patients who did not have the capacity to consent and we saw records in the notes of decisions made in the patient's best interests.
- Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS prevent was not mandatory in the trust. We were provided with a trust-wide list of staff who had undertaken the training, but it included few staff from OPD. This meant staff were at risk of not complying with the Mental Capacity Act code of practice 2007 in regards to patients lacking capacity consent to care and treatment. The trust told us there were monthly training sessions open to all staff where MCA and DoLS was covered. MCA and DoLS training was also provided within consent to treatment training. Staff had access to the trust's policies on the trust's intranet.

## Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Staff maintained the privacy and upheld the dignity of people using the service.
- Services supported patients to self manage their care where possible helping them to retain their independence and reduce the number of times they had to travel to the hospital.
- Feedback from people who use the service and those who are close to them was consistently positive about the way staff treated people.

# Outpatients and diagnostic imaging

- We spoke with eight patients who spoke positively about their experience. Patients told us they felt as if they were treated as individuals. Many patients had visited the hospital regularly for several years and told us they knew staff well and always felt supported.

## Compassionate care

- We observed that staff took all possible steps to promote patients dignity and they were given privacy at all times. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Friends and Family test scores for June 2016 with 247 respondents demonstrated 96% of patients would recommend the services to a friend or family member.
- Patients spoke positively about their experience. One patient who had been attending the hospital for 18 years told us staff were very courteous. They said staff listened and were reassuring. Another patient told us, 'Staff notice when patients are having problems and come over and check if I am okay.'

## Understanding and involvement of patients and those close to them

- Patients and their relatives were encouraged to be involved in decisions made about their care and treatment. We observed staff taking time to ensure that patients and relatives felt involved in the individual's treatment plan.
- We spoke with cystic fibrosis specialist nurses who told us they provided nurse led clinics and telephone consultations. They described how they provided home visits and supported patients to self-manage their care. They monitored some people over the telephone and by working with their GP. Patients were encouraged to contact them as soon as they experienced any change in their condition so that they could begin any treatment as soon as possible without necessarily having to travel to the hospital. Their approach was to educate and advise patients as far as possible to help them manage their own care.
- One member of staff told us about the 'Singing For Our Lungs' group and we saw this was advertised in the outpatient department to help patients with their breathing and meet other patients with a similar condition.

- Three patients we spoke with told us reception staff explained what would happen next following their appointment. They were encouraged to book any follow up appointments at the time and contact the clinic if the appointment time was unsuitable. Patients told us they usually received their test results on the day before they saw the doctor but if they required any further tests staff always explained when they would receive their results.

## Emotional support

- Patient records we looked at showed patient's physical and psychological needs were assessed and addressed, including pain relief, and anxiety. One patient told us they had been offered counselling by their doctor. They said their consultant had referred them and they thought this would be helpful. They said they were a single parent and appreciated the opportunity to talk through how they could support their family during their treatment. They said they were pleased to have been referred to the service because they were not only more confident about the treatment they were receiving but staff understood the impact of their condition on family life.
- Clinical nurse specialists (CNSs) were available to support patients when they received their diagnosis and afterwards if they had any question or required further information. We spoke with two specialist nurses who told us they supported patients to remain at home as far as possible by providing advice over the telephone. Some CNSs had completed training in prescribing and could provide patients with a prescription they could collect locally. CNSs also liaised with patients GPs to keep them informed to help support the patient.
- One patient told us how they had been encouraged to join a support group which they found really helpful.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated the service as requires improvement because:



# Outpatients and diagnostic imaging

- The trust consistently breached the target for patients to wait less than 62 days from urgent GP referral to starting treatment between quarter 3 of 2013/14 and quarter 2 of 2015/16. The trust was not actively working with referring trusts to improve pathways and referral times
- We were told the service did not record the time patients arrived in clinic, so waiting times were not routinely monitored.
- The Brompton outpatient service risk register highlighted that patients had to wait for longer than 12 months to be seen in the adult congenital heart disease clinics. The service was unable to see all the patients who had been referred. Patients often became unwell before they could be seen in clinic and there were problems reviewing follow up patients who had received their surgery.
- Figures provided by the trust showed 27% of clinics started late for the period April 2015-March 2016. The trust told us they were aware of the problem and were working on reducing the number of clinics which started late.

However,

- Staff described how patients in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required.
  - Long term patients were given an emergency number to contact if they needed to be seen urgently and could be seen on weekends on the ward by medical cover staff.
  - Radiology had slots available to accommodate urgent patients travelling long distances avoiding them making multiple journeys.
  - The trust met the national standard for referral to treatment rates each month for non-admitted pathways between April 2015 and March 2016 with the exception of October 2015.
  - The trust consistently exceeded the target for cancer patients to be seen by a specialist within two weeks of urgent GP referral between quarter 3 of 2013/14 and quarter 2 of 2015/16 aside from quarter 1 of 2014/15 and to receive first definitive treatment within 31 days of diagnosis.
- The percentage of diagnostic waiting times over six weeks was consistently lower than the England average between October 2013 and January 2016 with the exception of July 2015.

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

- The Brompton outpatient service risk register highlighted that patients had to wait for longer than 12 months to be seen in the adult congenital heart disease clinics. The service was unable to see patients who had been referred. Patients often became unwell before they could be seen in clinic and there were problems reviewing follow up patients who had received their surgery. The trust told us a project had been running throughout 2015-2016 to contact and review this patient group to confirm they were receiving appropriate follow up care and treatment. Patient's were contacted via their GP inviting them back for review. In the summer of 2106 the project was on track to be completed by the end of 2016. 25% of patients had been referred back to the trust for ongoing specialist care, 20% were under the care of another trust and therefore discharged and 15% no longer required follow up. Priority patients identified were reviewed in existing clinics and evening clinics. The project was due to be completed by the end of 2016.
- This remained a risk on the trust's risk register. The trust told us they now recognised a larger number of patients required long term follow up and were actively developing systems to ensure these arrangements were in place.
- There was a similar problem with heart failure patients who needed to be seen regularly to reduce the need for admission to hospital. The heart failure team were trying to develop their service but this was limited by the lack of capacity in the outpatient department
- We observed clear signposting through the hospital to the outpatients and diagnostic imaging departments.
- Patients told us they received instructions with their appointment letters and were given written information when needed.
- Waiting areas had sufficient seating available with access to toilets, a children's play area and a water dispenser. A shuttle bus service was available between both hospital buildings.



# Outpatients and diagnostic imaging

- A coffee shop was available in the outpatient department which recently extended its opening hours based on patient feedback. The nuclear medicine department offered patients free tea and coffee.
- Pagers were not available to patients; however we observed that appointments between outpatients and diagnostics were co-ordinated to allow patients to have diagnostic procedures whilst waiting for consultation minimising the time that patients spent at the hospital.
- Transitional clinics for patients changing from paediatric to adult care were organised so the patients do not have to miss any school time.
- The trust had invested in clinical nurse specialists for lung clinics to be held at Kingston, Harefield and Hillingdon hospitals.
- The Brompton outpatient service risk register highlighted that patients had to wait for longer than 12 months to be seen in the adult congenital heart disease clinics. The service was unable to see patients who had been referred. Patients often became unwell before they could be seen in clinic and there were problems reviewing follow up patients who had received their surgery. The trust told us a project had been running throughout 2015-2016 to contact and review this patient group to confirm they were receiving appropriate follow up care and treatment. Patients were contacted via their GP inviting them back for review. In the summer of 2016 the project was on track to be completed by the end of 2016. 25% of patients had been referred back to the trust for ongoing specialist care, 20% were under the care of another trust and therefore discharged and 15% no longer required follow up. Priority patients identified were reviewed in existing clinics and evening clinics. The project was due to be completed by the end of 2016.
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## Access and flow

- The trust was unable to tell us how many clinics were cancelled or how often the patient waited longer than 30 minutes in clinic to be seen. There was no facility for recording on the trust's patient administration system how long patients waited to be seen. Managers told us the system was due to be replaced in July 2016 when this facility would be available. The trust told us they monitored waiting times through the manual collection of data.
- Figures provided by the trust showed 27% of clinics started late for the period April 2015-March 2016. The trust told us they were aware of the problem and were working on reducing the number of clinics which started late.
- We were told the service did not record the time patients arrived in clinic, so waiting times were not routinely monitored.
- One patient told us they had waited 45 minutes to be seen but this was the longest they had waited. Another patient told us they were always seen on time or within a few minutes of their appointment time.
- We spoke to 20 patients in total and two patients said that they have had to wait 45 to 60 minutes to be seen but that this was the longest they ever have had to wait. The other 18 patients said that they were always seen on time or a few minutes around the appointment time. The patients we spoke to all agreed that they were satisfied with the waiting times and that they were well informed of any delays.
- We observed patients were called to clinic rooms for tests before they were seen by medical staff. Clinic staff managed the flow of patients through the testing area. This meant the main waiting area had approximately 20 patients waiting whilst other patients were being treated and seen in testing areas.
- The trust met the national standard for referral to treatment rates each month for non-admitted pathways between April 2015 and March 2016 with the exception of October 2015 when the rate fell to 60%. Non-admitted pathways are waiting times for patients whose treatment started during the month and did not involve admission to hospital.

# Outpatients and diagnostic imaging

- The trust consistently met and exceeded the target for 92% of cancer patients to be seen by a specialist within two weeks of urgent GP referral between quarter 3 of 2013/14 and quarter 2 of 2015/16 aside from quarter 1 of 2014/15.
- The trust consistently met and exceeded the target for 96% of cancer patients to receive first definitive treatment within 31 days of diagnosis between quarter 3 of 2013/14 and quarter 2 of 2015/16.
- The trust consistently breached the target for 85% of patients to wait less than 62 days from urgent GP referral to starting treatment between quarter 3 of 2013/14 and quarter 2 of 2015/16. The trust explained that this breach is due to the trust primarily treating specialised cases which typically take much longer to diagnose before they were referred on. The trust told us they only treated lung cancer patients which was a complex pathway and late referral to the trust was common. A programme for improvement internally and with referring trusts was in place.
- From October 2013 to January 2016 the trust met the national standard for diagnostic imaging waiting times (that is less than 1% of patients waiting more than six weeks), aside from July 2015. No patient waited more than six weeks for diagnostic imaging which was consistently better than the England average between October 2013 and January 2016, with the exception of July 2015.
- Patients told us they were offered a choice of appointment date and time, also they could ring up and change the appointment time if it was not convenient. The patients we spoke with told us they had never had their appointment cancelled by the hospital.
- Outpatients used a text messaging system to send patients appointment reminders. Nuclear Medicine telephoned all patients to remind them about their appointment time and answer any questions about their procedure.
- The “did not attend” (DNA) rate for the trust was lower than the England average during the reporting period of September 2014 to August 2015
- Delays to clinics were displayed on the electronic screens in the outpatient east. Clinical support assistant staff also verbally informed patients of any delays.

## Meeting people’s individual needs

- The trust treated patients from all English CCGs. The trust’s three highest ethnic minority groups were Indian (7.9%), Pakistani (2.9%) and Other Asian (2.9%). In 2013/14 0.2% of admissions were blind, 0.9% were deaf.
- CT scans were available on the day of a patient’s appointment if they had been referred under the two week referral pathway due to a suspicion of cancer.
- Staff described how patients in vulnerable circumstances were accommodated in the department and their appointment could be escalated if required. We were told that patients with severe learning difficulties or dementia were given a clinic room to wait in and seen quickly and that patients with severe physical disabilities can be accommodated and seen on the ward.
- Access to interpreting services could be arranged with 24 hour notice for those patients who did not speak English. In urgent cases a hospital wide email was sent to seek voluntary translators.
- Within the outpatient and diagnostic areas there was a wide range of patient information available about a variety of conditions and support services available. for example about chronic obstructive pulmonary disease, occupational lung disease and cystic fibrosis.
- Patient information was able to be ordered in any language, font size, braille and there was an audio induction loop.
- Provision for bariatric patients was available within outpatients including suitable equipment.
- We saw a poster in the outpatient department promoting a medicines helpline which patients and carers could phone or email with queries about medicines.
- Long term patients were given an emergency number to contact if they needed to be seen urgently, we were told that on weekends these patients could be seen on the ward by medical staff. A patient told us they were about to go on holiday and developed a chest infection, they contacted the service and received a prescription quickly which enabled them to go on holiday.

# Outpatients and diagnostic imaging

- Patients were given a numbered ticket when they attended adjacent departments for investigations such as x-ray or ECG. This enabled staff to call patients in order and monitor waiting times.
- We observed that patients travelling long distances were accommodated by having all their diagnostic tests and imaging completed on the same day to avoid them making multiple journeys. Radiology had slots available to accommodate for urgent requests
- Staff told us they had received training on dementia awareness which had increased their knowledge about caring for patients living with the condition.

## Learning from complaints and concerns

- One patient told us they knew how to make a complaint and understood the role of the patient advice and liaison service (PALS) but another patient said they did not know how to make a complaint. They said they would ask one of the staff if there was anything they were concerned about.
- Initial complaints were dealt with by managers in the outpatient and diagnostics departments in order to resolve issues locally; however information about the PALS team was always provided.
- Staff we spoke with explained that they directed patients to the PALS office should they wish to make a complaint and patients told us they knew how to make a complaint if needed.
- At a local level complaints were discussed in monthly staff meetings and the lessons learnt were recorded in local incident logs. At a trust level complaints data was looked at monthly governance sessions and outcomes were discussed at quarterly quality meetings.
- The trust provided us with information about the complaints they had received about outpatient and diagnostic services. There had been eight complaints about outpatient services and six about imaging between March 2015 and February 2016.
- One complaint related to acting on the results of a CT scan where cancer had been identified. The results had been entered on to the patient's electronic record but an outpatient appointment had not been arranged to give the patient their results. The patient's cancer was not diagnosed and they had not been referred to

palliative care before they died. The trust had upheld the complaint and put systems in place to reduce the risk of a similar incident occurring again. Follow up outpatient appointments were organised for patients where tests were carried out because cancer was suspected and the radiology reviewed abnormal results weekly to ensure they were all being followed up.

- Another patient was lost to follow up for several months. Patients were asked to return a slip to outpatient administration staff which indicates if follow up care is required. There was no system for identifying patients where no outcome is reported. The trust did not feel any further action was required because a new patient administration system was being implemented which would flag any patients where a consultation outcome had not been recorded. Four complaints in total were concerned with appointment delays and lack of continuity.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- There were clear governance and risk management processes in place.
- Staff in diagnostic imaging felt they contributed to improvements at work.
- The results of the 2015 staff opinion survey showed radiology scores for staff engagement were higher for radiology staff than many other clinical teams in the trust.
- Staff in outpatients and diagnostic imaging spoke highly of the trust's leadership who said they were visible throughout the Royal Brompton departments.

However,

- A strategy for the outpatient service had not been developed. Managers recognised capacity was a constraint which was limiting the provision of heart failure and congenital heart disease clinics. The

# Outpatients and diagnostic imaging

outpatient management team kept the utilisation of clinic space under review and re-deployed space for ad-hoc clinics. A strategy group had been set up to develop a strategy for outpatients.

- The management and oversight of diagnostic imaging services was split between the lung and heart divisions. An external review of the service had recommended creating a separate diagnostic imaging division to provide a clearer focal point for developing the services. The trust told us there was closer collaboration through the appointment of cross site clinical leads.

## Leadership of service

- We spoke with consultant chest physician lead for asthma also trust lead for respiratory medicine who spoke highly about leadership in the trust.
- The management of diagnostic imaging services was split between the lung and heart divisions. An external review of the service had recommended creating a separate diagnostic imaging division to provide a clearer focal point for developing the services.
- Staff working in diagnostic imaging spoke highly about their managers and told us they felt the department was well led.
- Nursing staff told us they had good support from their managers and they attended monthly meetings for nursing staff when they could.
- Staff in the outpatient department told us there were monthly meetings where they discussed clinic organisation and developments.
- Managers told us they were joined by executive level managers for executive safety walkabout. Outpatient managers told us they attended board meetings when outpatient performance or other issues were discussed.
- There was no executive leadership structure for diagnostic imaging or the outpatient service. Both services were managed within the clinical divisional structure with responsibility split for diagnostic imaging between the lung and heart division. We saw an external peer review report undertaken by senior clinicians from similar services in other trusts who recommended the creation of a directorate of imaging led by a head of imaging division responsible for service delivery of all imaging modalities and strategic departmental

development and organisation. The trust told us there was closer collaboration through the appointment of cross site clinical leads for cardiac magnetic resonance, nuclear medicine and cardiovascular CT.

- The diagnostic imaging services at the Brompton site largely operated separately from the Harefield site although, staff told us work was underway to create a fully integrated PACs requesting and reporting system which would create shared reporting and resilience between the services.
- The results of the 2015 staff opinion survey by staff group showed only 47% of radiology staff felt there was good communication between senior management and staff although 78% felt they contributed to improvements at work. Scores for overall staff engagement were higher for radiology staff than many other clinical teams.

## Vision and strategy for this service

- The trust was a specialist centre for diagnosing and treating heart and lung problems. The trust's vision was concerned with consolidating their specialist services to be the country's leading specialist centre for heart and lung disease and developing services through research and clinical practice. The vision also included extending the trust's reputation internationally. The trust's strategic objectives included improving patient safety and satisfaction, providing world class specialist treatment, supporting innovation in clinical practice, attracting world class clinicians and investing in leading age services and technologies. The trust had developed a set of values which included: care, respect inclusion. We saw posters on display in the outpatient department and within diagnostic imaging explaining the trusts strategy and objectives
- Staff we spoke with were aware of the trust's vision but some expressed frustration that issues for example the buildings and facilities required improvement and felt this should also form part of the trust's strategic objectives. Staff told us they knew about the trusts plans to develop a new building for outpatients. They said managers were forward thinking and made things happen.

# Outpatients and diagnostic imaging

- We asked the trust if a strategy had been developed for the outpatient and diagnostic imaging service and they told us a separate strategy had not been developed; the services were included in the trust wide strategy.
- We met with the managers and clinical directors of the service who told us the highest priority for the services was to modernise outpatient pathways. They told us there were examples of some consultations delivered by nurses or by using telemedicine but they wanted to review all the pathways across all specialties. They said this had been difficult with the information technology they had but the new system being installed in July 2016 would enable them to analyse patient pathways in more detail. The trust had commissioned a review of the medium term requirements over the next five years for radiology services
- Managers were aware that outpatient referrals were increasing by an average of 5% year on year and the service needed to modernise pathways to cope with increasing demand.
- There were divisional quality and safety groups which reported to the trust's Governance and Quality Committee. The Governance and Quality Committee was accountable to the executive level Risk and Safety Committee and through this group to the Trust Board.
- The heart and lung divisional performance reports included information about attendance rates for outpatients in subspecialty areas for example thoracic surgery and thoracic medicine, the referral to treatment times, numbers of procedures and length of inpatient stay.
- There was limited quality information available for the outpatient service because the service was included in the management of the lung and heart divisions. There were no separate quality and performance report for the outpatient service.

## Governance, risk management and quality measurement

- The trust provided us with a copy of a report produced for the July 2016 meeting of the trust's risk and safety committee. We also saw the risk register for the Fulham Road site where the outpatient department was provided. The highest risks related to the estate and the electrical supply to the building. Repairs were carried out where possible but the register recorded that the system needed replacing. Estates staff were working on the issue but it remained a significant risk because timescales for replacing the system had not been agreed.
- We saw the risk register for the nuclear medicine department which showed concerns about equipment failure, concerns about outpatient capacity and identifying patients correctly were all highlighted as the highest risks but it was not clear what actions had been put in place to mitigate these.
- Each department had their own local risk register and there was a trust wide register which was monitored by the trust's quality and safety committee.
- The results of the 2015 staff opinion survey showed radiology staff reported the highest response rate of any clinical group experiencing harassment, bullying or abuse from staff in the 12 months before the survey. 96% of radiology staff reported working extra hours the highest of all the clinical staff groups although only 50% felt any pressure to work extra hours which was less than some other clinical groups
- Radiology staff told us there was some pressure to meet targets but they were also working on ways of improving how services were organised and delivered.
- The culture within the outpatient department was positive. Staff told us there had been vacancies in admin staff and in the senior nurses post in outpatients west but they had pulled together as a team to make sure things ran smoothly.
- Reception staff told us they met monthly to discuss the organisation and administration of outpatient clinics.

## Culture within the service

## Public engagement



# Outpatients and diagnostic imaging

- The cystic fibrosis service had surveyed patients' views. They had contacted all 600 patients who were cared for by the service and improved patient pathways based on the results received.
- When we visited the lung function laboratory we found they had recently reviewed their patient pathway and introduced a one stop clinic as a result based on the feedback they received from patients.
- The trust used the NHS friends and family test for obtaining feedback on the service. The FFT score for the outpatients department in June 2016 was 96% with a response rate of 247.
- We saw the results of a survey undertaken by the outpatient department about communication between the service and patients. 80% of the patients who responded indicated they would like to receive a communication from the trust when their referral had been received. 93% of patients responded positively to a question about being reminded even days before their appointment. 44 patients had responded to the survey, 25 of whom were adults the rest were children and their families.
- The trust had involved patients in reviewing their complaints process. The key findings were that patients felt comfortable making a complaint and speaking up and generally found the process simple. The patients who did not feel their issue had been resolved remained dissatisfied and would not make another complaint as they felt it did not make any difference. The trust concluded that the engagement exercise had provided value learning about the effectiveness of the complaints process.
- We saw the results of a patient survey carried out in January 2016 for diagnostic imaging. The survey asked if it was easy to find the department, if they were seen on time, if their procedure was fully explained, and if the department felt safe. The majority of patients who responded indicated they had waited for five minutes on average before being seen and staff had been very friendly.

## Staff engagement

- The results of the 2015 staff opinion survey showed staff engagement was better than other trusts with a score of

4.2 out of 5. The results by staff groups showed radiology were more likely to recommend the organisation as a place to work than other staff groups and that they felt there was effective team working.

- 100% of radiology staff who responded agreed that their role made a difference to patients. However, radiology staff also felt less satisfied with the level of resources and support they received compared to other staff groups.

## Innovation, improvement and sustainability

- The trust supported innovation projects using an international improvement methodology. Staff submitted bids for project funding. One of the projects submitted involved improving the adult cystic fibrosis outpatient pathway journey which resulted in reducing the overall clinic length, reducing clinic overruns and improving the patient flow. The project won a prize and the staff involved supported other staff to develop their own improvement projects.
- Development of a one-stop clinic for patients with unexplained breathlessness
- The catheter lab had implemented a dose tracking system (DTS), which provided real time spatial radiation dose information to reduce risk of radiation injury.
- Radiography staff had extended their role to provide image guided percutaneous indwelling central catheter service (PICC), using ultrasound and fluoroscopy guided line insertions for patients requiring long term access or without visible veins
- A digital care transformation programme was in progress to improve patient experience in outpatient by improving patient pathways.
- Improvements had been implemented in the lung function laboratory as a result of using improvement techniques such as process mapping. All the staff in the department had been involved in identifying where the process could be improved resulting in re-organising appointments and the flow through the department was changed to improve the rate at which diagnostic tests were carried out.



# Outstanding practice and areas for improvement

## Outstanding practice

We observed several areas of outstanding practice:

### Medicine

- The multidisciplinary working of the medicine services at the Royal Brompton Hospital offered both a clinical and holistic look at the patient's needs.
- All staff within the medical division at the Royal Brompton Hospital felt actively engaged by their leaders and spoke very highly of their managers.

### Children and young people

- SPRinT training has won National awards Delegates attend the training from all over the world. The training has been taught and has commenced at other hospitals nationally.
- Royal Brompton policies were being used internationally, for example, the Cystic Fibrosis (CF) policy and guidelines were used and had International acclaim.

## Areas for improvement

### Action the hospital MUST take to improve

**There were also areas of poor practice where the trust needs to make improvements:**

### Medicine

- The trust must ensure that hand hygiene practices are clear throughout medical wards and make antibacterial gel obvious to visitors and relatives of patients.

### Surgery

- The trust must ensure operating procedures are in place are reliable to ensure the cleanliness and safety of equipment in theatres.

### Critical Care

- The hospital must ensure hand hygiene practices are rigidly followed by all staff at all times and that infection control practices are embedded in all clinical areas.

### Action the hospital SHOULD take to improve

### Medicine

- All medical wards should ensure that patient medical records are locked away.
- All medical wards should ensure corridors are free from clutter.

### Surgery

- The hospital should ensure all staff who are involved in the care and treatment of children and young people are trained in level three safeguarding.
- The hospital should ensure the use of the World Health Organisation (WHO) five steps to safer surgery checklist is fully embedded and utilised appropriately by all staff.
- The hospital should ensure staff in theatres received adequate rest periods following on-call work.
- The hospital should ensure the nursing management in theatres is appropriate and effective in the way in which change is managed throughout the department ensuring that all staff feel valued and involved.

### Critical Care:

- The hospital should ensure areas used to store medicines can be temperature-controlled and that this is monitored at least daily
- The hospital should ensure junior doctors have access to and understanding of robust, structured support in place that enables them to develop professional and clinical competencies.
- The hospital should ensure new consultants receive an adequate induction that meets their individual needs.

# Outstanding practice and areas for improvement

- The hospital should ensure quality monitoring and risk management processes are accessible and understood by all staff and that there are clear links between such processes and how staff practice.

## End of life care

- The hospital should ensure that further formal training in End of life care (EOLC) is implemented for staff across the hospital, as detailed in their educational plan.
- The hospital should train all porters annually in infection prevention and control and keep a formal record of this training.
- The hospital should ensure that a validated assessment tool to document care of patients at the end of life is rolled out across the hospital and that all staff are familiar with this.

- The hospital should improve data collection methods surrounding issues relating to EOLC in order to enable benchmarking and audits.
- The hospital should improve seven-day access to specialist palliative care provision.
- The trust should consider introducing a lay member to the trust board with responsibility for EOLC, in addition to the lay member who attends the EOLC steering group.

## Outpatients and Diagnostic Imaging

- The hospital should ensure all outpatients department clinics start at their published time, and consultants do not accept work commitments inside the hours specified in their job plans.
- The hospital should reduce the time patients spend waiting in the outpatients waiting room.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The trust is failing to comply with this regulation because it is not consistently assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated.</p> <p>Systems, processes and standard operating procedures were not always reliable or appropriate to ensure cleanliness and safety of equipment and the environment in theatres.</p> <p>There were failures in infection control practices. This included variable hand hygiene audit results, inconsistent nurse practice and inadequate handling of intravenous fluids.</p> <p>Regulation 12(1)(2)(h) HSCA (RA) Regulations 2014 Safe care and treatment</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The trust is failing to comply with this regulation because it is not assessing the risks to the health and safety of service users receiving the care or treatment, or doing all that is reasonably practicable to mitigate such risks.</p> <p>National Early Warning Score (NEWS) charts were not always used appropriately to guide escalation.</p> <p>The World Health Organisation (WHO) five steps to safer surgery checklist was not fully embedded.</p>

This section is primarily information for the provider

## Requirement notices

Regulation 12(1)(2)(a)(b) HSCA (RA) Regulations 2014  
Safe care and treatment