

# Guy's and St Thomas' NHS Foundation Trust

## Guy's 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

Good 

Urgent and emergency services

Good 

Medical care

Good 

Surgery

Good 

Critical care

Good 

End of life care

Good 

Outpatients and diagnostic imaging

Good 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Guy's Hospital is part of Guy's and St Thomas' NHS Foundation Trust. The trust provides local acute and community services for people living in the London Boroughs of Lambeth, Southwark and Lewisham; and specialist services for patients from further afield. Guy's Hospital provides acute hospital services to an inner city population of around 975,885.

Guy's and St Thomas' NHS Foundation Trust employs around 12,586 whole time equivalent (WTE) members of staff with approximately 3,637 staff working at Guy's Hospital.

We carried out an announced inspection of Guy's Hospital between 7 and 10 September 2015. We also undertook unannounced visits to the hospital on 21 and 23 September 2015.

Overall, this hospital is rated as good. We found urgent and emergency care, medical care, surgery, critical care, outpatients and diagnostic services and end of life care were good.

Our key findings were as follows:

### Safe

- There was a positive culture of incident reporting. Incidents related to safeguarding were appropriately recorded and actions were taken to address them.
- Measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited.
- In most areas, staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and knew how to access the safeguarding team for advice and guidance when required.
- There were sufficient doctors and registered nurses on duty and good retention of nursing staff.
- In most cases, patient records, including prescription charts were fully completed and medicines were stored and administered appropriately, including controlled drugs.

### Effective

- Policies, procedures and protocols reflected best practice and guidelines from statutory and professional bodies.
- Multidisciplinary working functioned effectively.
- Staff were well supported with access to training, clinical supervision and development.
- Patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available and drinks were left within easy reach.
- Most staff understood the basic principles of the Mental Capacity Act, 2005 and could explain how the principles worked in practice. However, in some areas, there was inconsistency in how staff recorded capacity assessments and there was no evidence to support that staff had received training in the Mental Capacity Act 2005 or DoLS.
- In critical care, fewer than the recommended 50% of staff had completed a post registration critical care nursing award.
- Understanding of Deprivation of Liberty Safeguards was variable between staff and practice was not embedded in this area.

### Caring

- Patients received compassionate care and were treated with dignity, respect and privacy and involved in their care.
- Patients receiving end of life care received good care.

# Summary of findings

- Patients were happy with the standard of care they had received and they felt staff had a genuine interest in helping them.
- Patients and their relatives were positive about their experience of care and the kindness afforded them.
- Emotional support was provided by staff in their interactions with patients.

## **Responsive**

- Complaints were taken seriously were investigated using a process that was evidence-based to ensure that learning took place.
- Discharge plans were commenced on admission and most patients had estimated dates of discharge documented in their records.
- In surgery, there were some challenges with referral to treatment waiting times due to demand outstripping capacity, but this was being addressed appropriately.
- Information leaflets were available in waiting areas and were provided to patients by staff.
- Outpatient and diagnostic imaging services were not always responsive as the trust was persistently failing to meet the national waiting time targets related to cancer treatment.

## **Well-led**

- Most staff were aware of the trust vision and incorporated this as part of their daily work.
- Staff showed a positive attitude to their work and spoke well of the trust and their colleagues.
- Senior managers were supportive to their staff and were visible on the wards.
- Patients were engaged in service development.
- The surgery service was innovating in a number of areas to improve patient outcomes and build capacity within the service, including highly effective multi-disciplinary outreach services.
- There were effective governance processes in place and staff were able to provide examples of feedback and learning points.
- Most staff felt empowered to drive forward initiatives and improvements.

We saw several areas of outstanding practice including:

- The SPCT was effective and provided face to face support seven days per week with visits up till 9pm and calls till 11pm and a consultant providing out of hours cover
- The Amber care bundle and a range of training courses for staff in end of life care such as the Sage and Thyme training model, Simulation days and Schwartz rounds.
- The Guy's Orthopaedic Outreach Team (GOOT): a fast track discharge and multi-disciplinary support service which improved patient outcomes and reduced length of stay.
- Proactive Care of Older People Service (POPS): an award-winning service and the first of its kind in the UK. The POPS service looks after patients aged 65 years and above to improve their medical health before and after surgery by assessing them before surgery, following their care while in hospital and supporting consultants and ward staff.
- The use of 'Barbara's story' to engage with staff and enhance a compassionate approach to patient care.
- Supportive practice of the mortuary and bereavement team.
- Staff in the bereavement office had sourced funding to provide family members with sympathetically designed cloth bags so they had a more discreet way of taking home personal belongings of a deceased patient, rather than use a plastic hospital property bag.

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

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

- Improve governance links between directorates with surgical activity to ensure learning and concerns are shared across these directorates in a timely way.

# Summary of findings

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

- Take steps to increase the number of day surgery cases to reduce bed demand and reduce length of stay. The trust should consider introducing a named day surgery clinical lead to improve coordination of day surgery and provide a single contact for surgical directorates.
- Take steps to improve the working culture within theatres to ensure that all theatre staff have fair access to learning and development opportunities.
- Continue embedding and monitoring use of the 'five steps to safer surgery' WHO surgical safety checklist, with a particular focus on pre-briefing and de-briefing.
- Ensure consent for surgery is clearly documented in patient records and patients are given adequate time and documentation to make decisions about their care in advance of their planned procedure date.
- Improve engagement with lifestyles teams in tertiary, secondary and primary care to help surgery patients with smoking cessation, weight loss or exercise programmes to improve local health outcomes.
- Review the process for completing DNACPR forms and determine a specific location where they are kept for end of life care patients .
- Improve the consistency of mental capacity assessments and the recording of them for patients receiving end of life care.
- Review the escalation process when delays occur with the completion of death certificates.
- Reduce delays in 31/62 days cancer waits (diagnosis and treatment) in Outpatients.
- In the outpatients department, ensure all staff are aware of protocols related to obtaining patients' consent; including protocols for those who might lack capacity to make a decision".
- Ensure all incidents in the outpatients department are investigated promptly and outcomes of the investigations recorded and shared with team to prevent recurrence.
- In the outpatients department, ensure all staff receive mandatory training and are appraised regularly as prescribed by trust's policies related to staff training and development.
- On Samaritan Ward, review the provision of toilet facilities for patients.
- Improve mandatory training completion by staff on the medical wards/departments.
- Improve performance on the number of patients starting treatment within 62 days for upper and lower gastro-intestinal illnesses.
- Ensure all staff, including staff working in outpatients departments, are provided with basic life support training.

Professor Sir Mike Richards

## **Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

The trust had only recently taken over responsibility for the service prior to the inspection and has not supplied any patient outcome data provided that was specific to the UCC. Therefore, we did not know whether the UCC was performing better or worse than similar units. The team working in the department were dedicated to providing a safe and efficient service that took into account the needs of the local population. Staff were skilled at caring and treating for patients with complex needs and those who needed a referral to a more appropriate service. Staff had been trained to ensure that patients who could not communicate verbally could be assessed and treated effectively.

Our interviews with staff and review of documentary evidence in the department showed us that management and leadership structures were conducive to a department that operated with openness and transparency. This was evident in the way staff approached incident reporting and investigations and the handling of complaints. Learning from such instances was embedded into service planning and detailed root cause analyses ensured that investigations were fair and thorough.

The streaming processes in the department were well established and meant that ENPs consistently met the target of seeing each patient within 15 minutes of their registration. Patient attendance rates were monitored on a monthly basis and were used to plan staffing levels to effectively meet times of high demand. The interactions we observed between patients and staff were positive and the patients we spoke with told us they were happy with the service they had received. The environment was clean and tidy and staff complied with trust infection prevention and control policies. Equipment was maintained to an appropriate standard and had been checked regularly. Medicine storage met the requirements of the National Institute for Health and Care Excellence and staff were appropriately trained for the administration of medicines.

### Medical care

Good



Between April 2014 and March 2015, Guy's Hospital did not meet the Referral to Treatment target (admitted) of 90 % but did so in 88.9% of cases.

## Summary of findings

There was a positive culture of incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited. There were sufficient doctors and registered nurses on duty, staffing levels were tracked four times a day across the hospital. Patients who were deteriorating were seen by advanced nurse practitioner and had their care re-assessed.

Staff were well supported with access to training, clinical supervision and development. National Institute for Health and Care Excellence guidance was used across a range of conditions. Patients' nutritional needs were assessed with scores recorded and risks identified.

Consultants covering oncology and haematology were available seven days per week. Patients were asked for verbal consent to be treated and we saw consent forms to treatment forms had been signed by the patients prior to medical procedures.

Patients received compassionate care and were treated with dignity and respect. Patients and relatives and their relatives were positive about their experience of care and the kindness afforded them. Patients told us they were involved in decisions about their care and treatment and were given the right amount of information. The trust had a higher response rate to the Friends and Family test (FFT) than the England average. We found evidence of monitoring of patient outcomes through a range of audits and national guidance was used to inform patient care and treatment.

The hospital proactively managed patients discharge. Where a patients discharge was delayed this was escalated to the discharge team to progress. 74% (3,444) of patients experienced no ward move and were treated in the correct speciality bed for the entirety of their stay. Patients had their needs assessed and fundamental care rounds were undertaken at different times of the day. Formal complaints were managed through the Patient Advice and Liaison Service (PALS), they were investigated with learning points identified and fed back to staff.

Staff were aware of the trust's vision and incorporated this as part of their daily work. The culture within the division was of openness and honesty. Ward managers were provided with regular reports on incidents,

# Summary of findings

complaints, survey results and staffing data. Trends could be readily identified and learning was disseminated to staff. Staff reported they were supported by their managers and department heads. We found that staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

## Surgery

Good



The trust mandated staff to use all five steps of the World Health Organisation (WHO) Surgical Safety Checklist in theatres, including team briefing and de-briefing components, in May 2015. Prior to this, staff were primarily expected to use the three central steps (sign in, time out, sign out) only. We witnessed some surgeons completing the five steps of the WHO checklist thoroughly and in full. However, we also found some inconsistencies in the application of briefings and de-briefings by some surgeons.

We found good levels of cleanliness, infection control and hygiene across surgery wards and in theatres. Staffing in wards and theatres was good with very low use of bank and agency staff, and there was good retention and management of nursing turnover. There was good completion of mandatory training and effective systems in place to report incidents. However, we found that the sharing of learning from incidents could be improved.

Surgical patients received effective care and treatment that met their needs and there was evidence of positive feedback from patients. Their care and treatment was planned and delivered in line with national and local guidelines. Patients were treated with compassion, dignity and respect. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the hospital and its surgery services.

We found very effective multidisciplinary team working between doctors, nurses, physiotherapists and other allied health professionals. Information was shared proactively between staff groups to ensure good coordination of patient care on wards and to help discharge patients more rapidly. However, this effective team working was sometimes impacted by delays elsewhere in the hospital, particularly in obtaining prescription drugs from the pharmacy.

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

# Summary of findings

## Critical care

Good



service had a clear vision and values. There was high morale amongst staff, particularly on the wards. Staff were supported by their managers and there was a culture of openness to learn and develop services. Performance information was shared within each of the directorates delivering surgical services, but we found limited formal structures for governance information to be shared between the directorates delivering surgical activity. Staff were given opportunities to provide feedback and inform service development. They were also supported by managers to develop their knowledge and skills to improve the quality of care provided to patients.

Patients achieved positive outcomes, including good safety thermometer results and a better mortality rate than other similar units. This was due evidence-based care delivered by safe numbers of competent staff. Patients could access the service without delay and there was suitable patient flow through the unit. There was positive safety reporting culture within critical care and investigations completed as a result highlighted learning points which were clearly communicated to ward staff. Patient records including medicines administration charts were fully completed and medicines were appropriately managed. Staff were caring and maintained patient privacy and dignity during their admission to the unit. We observed staff treating patients with respect and obtaining consent from patients prior to performing care tasks. Patient and relative feedback about the care they received was positive and there were good facilities for relatives. There were few formal complaints received by the unit and we noted the actions taken in response to informal feedback.

Staff were comfortable approaching the leadership team with any issues and were encouraged to develop professionally. The management team had good oversight of the unit however, vision for improvements to Guy's Critical Care Unit was minimal and the primary goal for developing critical care within the trust was focused at St Thomas' Hospital.

Staff knowledge of safeguarding principles and Deprivation of Liberty Safeguards was limited and appropriate practice in these areas was not embedded. Staff appraisal rates were low and less than the recommended 50% of nursing staff had a post



# Summary of findings

registration award in critical care nursing. We saw no immediate action in place to ensure sufficient stock of some medicines over weekends which meant some patients missed doses of certain medicines for three weekends in a row.

## End of life care

Good



We saw that patients benefited from a multi-disciplinary approach to care. Generalist nurses and medical staff worked alongside the specialist palliative care team (SPCT) to deliver a cohesive plan of care.

Staff at Guy's Hospital provided skilled and compassionate end of life care to patients. The SPCT was effective and provided face to face support seven days per week including 24/7 community visiting. Due to staff shortage at the time of the visit on call was restricted to visits until 9pm and calls taken until 11pm. The Consultant rota remained unchanged during this period.

There was good leadership of the SPCT. Staff felt senior managers were willing to help, offered support and guidance, were often seen on the wards and were very approachable. We found many examples of innovative practice, including the AMBER care bundle and a range of training courses for staff in end of life care such as the Sage and Thyme training model, simulation days and Schwartz rounds. Staff in the bereavement office had sourced funding to provide family members with sympathetically designed cloth bags so they had a more discreet way of taking home personal belongings of a deceased patient, rather than use a plastic hospital property bag.

The hospital had a long term vision and strategy plan around end of life care. This had been drafted by external advisors and staff commented that it was not, in its current form, wholly achievable but it was under review. Staff were clear their focus was on providing individualised care, with quality outcomes and multi-disciplinary input. The SPCT encompassed national guidance into its end of life care protocols and practice such as the NHS guidance – Priorities for the Care of the Dying Person and One Chance to get it Right - developed by the Leadership Alliance for the Care of Dying People (LACDP). It also referenced to the NICE quality standards for end of life care.

Bereavement support was available from a number of sources – staff in the bereavement office, the social workers attached to the SPCT and the chaplaincy. We

# Summary of findings

visited a number of wards and observed patients being cared for with dignity and respect. Staff facilitated rapid discharge of patients to their preferred place of death. Medicines were provided in line with guidelines for end of life care. Feedback from patients and relatives, both in person during the inspection and gathered by the hospital in its own bereaved carer survey, was overwhelmingly positive.

The hospital was in the process of moving to wholly electronic based records. We found that during this process staff needed to use three different software systems as well as paper records, which led to some confusion and uncertainty around where to find key information. This was particularly noticeable with regard to 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. We found there was no consistency in the recording of mental capacity assessments.

From January to December 2014 there had been 971 deaths at the Trust.

## Outpatients and diagnostic imaging

Good



Outpatients and diagnostic imaging services provided at the hospital were safe, caring and well managed.

However, we observed that the services were not always responsive as the hospital did not meet national targets related to cancer treatment and performed below the England average since April 2013.

We found there were effective systems for monitoring quality of services and risks associated with its delivery. The hospital was able to assess and respond to patients' risk accurately because it collected accurate data, analysed it, and had effective systems for monitoring patients' referrals and cancellations. The trust met the national waiting time targets for non-urgent referrals. Staff felt empowered, they were able to take initiative to improve the hospital's performance. We observed strong local and senior leadership, managers were aware and able to oversee outpatients' activity at the hospital. Patients' treatment was well planned; good planning allowed preventing delays to treatment and improving patients' experience. Necessary information, including patients' medical records, was easily available. Patients were treated with compassion, dignity and respect; they felt fully involved in decisions about their care and treatment.

# Guy's Hospital

## Detailed findings

### Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging

# Detailed findings

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## Background to Guy's Hospital

Guy's Hospital is one of two registered acute hospital locations of Guy's and St Thomas' NHS Foundation Trust, which we visited during this inspection. The other hospital we visited was St Thomas's Hospital and we also visited the community services that the trust provides.

Guy's Hospital has 269 beds and is in the London Borough of Lambeth. The lead clinical commissioning group is Lambeth, which co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups.

## Our inspection team

### Our inspection team was led by:

**Chair:** Ellen Armistead, Deputy Chief Inspector, Care Quality Commission (CQC)

**Head of Hospital Inspections:** Margaret McGlynn, Care Quality Commission (CQC)

The hospital was visited by a team of 56 people, including: CQC inspectors, analysts and a variety of

specialists. There were consultants in emergency medicine, medical care, surgery, and palliative care medicine. The team also included nurses with backgrounds in medicine, surgery, critical care and palliative care. There were also specialists with board-level experience, a student nurse and two experts by experience.

## How we carried out this inspection

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

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

- Is it well-led?

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

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

# Detailed findings

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

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Trust Development Authority, Health

Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch. We also received information from the trust's council of governors.

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

## Facts and data about Guy's Hospital

### Context

- Guy's Hospital is based in South East London and serves an inner city population of 975,885 in the London boroughs of Lambeth, Southwark and Lewisham and provides specialist services for patients from further afield.
- The hospital offers a range of local services, including: an urgent care centre, medicine, surgery, critical care and outpatient clinics. Maternity and paediatric services are not available at this hospital. Specialist services are available to patients, which provide nationally and internationally recognised work in nephrology (kidney) and haematology.
- In the 2011 census, the proportion of residents who classed themselves as white British was 40.1% in Southwark and 56.7% in Lambeth and 53.5% in Lewisham.
- Lambeth ranks 29th out of 326 local authorities for deprivation (with the first being the most deprived). Southwark ranks 41st and Lewisham 31st.

### Activity

- The hospital has approximately 269 beds including 13 critical care beds.
- The hospital employs 3,637 Whole Time Equivalent (WTE) staff. Across the trust, the workforce was supported by an average of 14% bank/agency and locum medical staff between March 2014 to April 2015.
- There were approximately 19,549 inpatient admissions, including day case activity in 2014/15.

- There are approximately 746,804 outpatient appointments per annum.
- The urgent care centre saw 47,611 patients between January 2014 and August 2015.
- There were 248 deaths at the hospital between April 2014 and May 2015.

### Key intelligence indicators Safety

- Nine never events were reported between September 2014 and August 2015. Two occurred at Guy's Hospital. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between May 2014 and April 2015, there were twenty one serious incidents at Guy's Hospital.
- There were 12,792 incidents reported to NRLS between July 2014 and June 2015, of which 0.003% (34 in total) caused death or severe harm to the patient.
- There were 86 cases of C Diff in this trust between September 2013 and April 2015, and six cases of MRSA.
- There were 5 falls, 8 pressure ulcers and 6 CAUTIs reported to the Patient Safety Thermometer between June 2014 and June 2015.

### Effective

- We asked the trust to break down the following information by hospital site, but they were not able to do so.

# Detailed findings

- The HSMR for this trust for July 2013-June 2014 was 78.0 (no evidence of risk), with a rate of 69.8 during the week (no evidence of risk) and 72.2 at the weekend (no evidence of risk).
- The SHMI for this trust for January 2014 to December 2014 was 0.8 (lower than expected).
- There were no mortality outliers in this trust.

## Caring

- From the CQC inpatient survey 2014, this trust performed about the same as other trusts for all questions.

## Responsive

- We asked the trust to break down the following information by hospital site, but they were not able to do so.
- Between June 2014 and June 2015, the trust received 934 complaints. Of these, 426 related to treatment at the Guy's Hospital.
- For non-admitted patients, referral to treatment performance has been below target since September 2014. For admitted patients during the same period, the RTT standard was met consistently across medical specialties where data was available. The referral to treatment standard for incomplete pathways was consistently met throughout the period.
- The trust has consistently met the operational standard for 93% of cancer patients to wait less than 31 days from diagnosis to first definitive treatment between April 2013

and March 2015. However, the trust consistently failed to meet the standard for 85% of cancer patients to wait less than 62 days from urgent GP referral to first definitive treatment.

## Well-led

- We asked the trust to break down the following information by hospital site, but they were not able to do so.
- The overall engagement score for the Department of Health NHS Staff Survey for 2014 (for the trust as a whole) was 3.96, which was better than the England average of 3.75.
- The results of the 2014 Department of Health NHS Staff Survey demonstrated that for the Guy's and St Thomas' NHS Foundation Trust most scores were within expectations, in line the national average over the 29 key areas covered in the survey. These included the facts that the trust scores were:
  - Within expectations in 12 key areas.
  - Better than average in 11 key areas.
  - Worse than average in 6 key areas.
- The response rate for the staff survey was 35%, which was lower than the national average of 42%.

## Inspection history

This is the first comprehensive inspection of Guy's Hospital.






## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	N/A	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	 <b>Outstanding</b>	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Good	Good	Good	Good	Good	Good

# Urgent and emergency services

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

## Information about the service

The Urgent Care Centre (UCC) at Guy's Hospital provides a seven-day service from 8am – 8pm. Between January 2014 and August 2015, the UCC saw 47,611 patients. The department is able to see patients over one year old and does not treat patients with critical or life-threatening illnesses or injuries. A team of emergency nurse practitioners (ENPs), who work between Guy's UCC and the emergency department (ED) at St Thomas' Hospital, staff the UCC along with GPs from an out of hours (OOHs) GP service. There was no written, ratified agreement between the trust and the OOHs GP service to establish an agreed level of service.

Patients present to the department by walking into the reception area from the ground floor of Guy's Hospital. There are signs at the main hospital entrance to advise people that this is not an emergency department and cannot accept ambulance arrivals. Patients are booked in at the reception desk by a receptionist who 'streams' them to be seen by either an ENP or a GP, depending on their symptoms and condition. If a patient presents with a condition that cannot be treated appropriately at the UCC, they are referred to St Thomas' Hospital ED. Receptionists are able to call for an emergency ambulance if needed.

There are eight consultation rooms that are staffed by up to four ENPs and two GPs at the same time. A resuscitation room is available in the event a patient becomes critically unwell. Radiology is situated on the second floor of the same building and provides services at all times the UCC is open. The unit was returned to the responsibility of Guy's

and St Thomas' NHS Foundation Trust in 2014 and is managed by the head of nursing and service manager at St Thomas' Hospital. There is a bright and spacious waiting area and the unit was built in 2012.

During our inspection we spoke with six members of staff and three patients.



# Urgent and emergency services

## Summary of findings

We asked the provider to break down the data specific to the UCC and the ED at St Thomas's and they were not always able to. Effectiveness of the urgent care centre was not rated as the trust had recently taken over as the provider of the service and did not supply any patient outcome data provided that was specific to the UCC. Therefore, we did not know whether the UCC was performing better or worse than similar units.

The team working in the department were dedicated to providing a safe and efficient service that took into account the needs of the local population. Staff were skilled at caring and treating for patients with complex needs and those who needed a referral to a more appropriate service. Staff had been trained to ensure that patients who could not communicate verbally could be assessed and treated effectively.

Our interviews with staff and review of documentary evidence in the department showed us that management and leadership structures were conducive to a department that operated with openness and transparency. This was evident in the way staff approached incident reporting and investigations and the handling of complaints. Learning from such instances was embedded into service planning and detailed root cause analyses ensured that investigations were fair and thorough.

The streaming processes in the department were well established and meant that ENPs consistently met the target of seeing each patient within 15 minutes of their registration. Patient attendance rates were monitored on a monthly basis and were used to plan staffing levels to effectively meet times of high demand. The interactions we observed between patients and staff were positive and the patients we spoke with told us they were happy with the service they had received.

The environment was clean and tidy and staff complied with trust infection prevention and control policies. Equipment was maintained to an appropriate standard and had been checked regularly. Medicine storage met the requirements of the National Institute for Health and Care Excellence and staff were appropriately trained for the administration of medicines.

## Are urgent and emergency services safe?

Good



The UCC had systems in place that ensured people received timely and appropriate care and treatment. Staffing levels were maintained at consistently safe levels and were flexible to meet increased demands on the service during busy times. ENP staff had access to a well-structured system of mandatory training as well as additional specialist training to support them in the UCC, including leadership training. Training could be requested through the lead ENP or through the practice development nurses.

There was a culture of incident reporting and we saw that detailed root causes analyses had taken place following incidents. Staff were able to tell us in detail about learning from incidents and it was clear that managers encouraged staff to challenge routine practice and work towards service enhancements and improvement.

Safeguarding and child protection processes were embedded in the operation of the department and staff were able to tell us how these worked in practice. Major incident awareness was very good and staff had received up to date training on their responsibilities in a major emergency.

### Incidents

- The UCC had not had a Never Event (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). The unit had experienced one serious incident that had been reported to the National Reporting and Learning System. A detailed and exhaustive root cause analysis investigation had been completed that had included incident mapping, process mapping, a service delivery evaluation and the identification of contributing factors to the incident. Learning from the incident had been embedded into practice through the updating of information available to NHS 111 staff regarding the scope of the service in the UCC and a detailed review of the evacuation of seriously ill children plan. We saw that staff had liaised effectively with the Evelina London Children's Hospital and that the UCC team involved had been offered counselling after the incident.

# Urgent and emergency services

## Duty of Candour

- Staff were aware of their responsibilities under the Duty of Candour and were able to discuss confidently, how they ensured compliance with this. A prompt for the Duty of Candour formed part of the Datix incident reporting system and required staff to have discussed the incident with the patient or family member before submitting their report.

## Cleanliness, infection control and hygiene

- Staff followed the trust's infection prevention and control policies and followed good hygiene practices. We saw consistent use of antibacterial hand gel and the use of personal protective equipment, including gloves. Patients and visitors were encouraged to use antibacterial hand gel on entering and leaving the department.
- Cleaning audits were completed on a monthly basis using National Patient Safety Agency National Cleaning Standards. The latest available results were for April - June 2015 and showed an overall average compliance of 98%, which met trust standards.

## Environment and equipment

- The waiting and treatment environments were clean, hygienic and well maintained. Equipment had been regularly tested for safety and Portable Appliance Testing (PAT) stickers were dated and visible on all equipment we looked at. Resuscitation equipment was in a good state of repair and available for rapid access and use.

## Medicines

- We looked at the storage of medicines in the UCC. They were stored in a locked cupboard that adhered to the guidance of the National Institute of Care and Clinical Excellence (NICE).
- ENPs in the department had been certified in the safe administration of medicines and had completed observational checks by practice development nurses (PDNs). Some ENPs were designated nurse independent prescribers and were able to prescribe medicines against guidance from the Royal College of Nursing (RCN).

## Records

- The UCC used two different electronic systems for patient records that were not compatible with each other. One system was the same as the trust used in the ED at St Thomas' hospital and the other was the

in-house system for Guy's Hospital. This meant that there could be a delay in locating the details of a patient because staff had to check both systems. Reception staff we talked with showed us that there was a manual process in place for patient details to be duplicated to both systems to reduce delays and that this had never impacted or delayed medical treatment.

- We looked at the notes of ten patients and found them to be complete with details of their initial assessment, pain management and risk assessments where appropriate, such as for falls.

## Safeguarding

- Staff we spoke with had a good understanding of safeguarding procedures and were able to explain to us the trust's policy. In the first instance of a safeguarding concern staff would check the patient's electronic records to find out if information was known about them that could be used to ensure appropriate care and treatment was provided.
- Staff in the UCC worked to the trust's child protection policies. This included checking for alerts placed on the electronic records system that would indicate to staff that the child was cared for under a local authority child protection plan. Reception staff completed a notification for each child attendance that was sent to the health visitor liaison group as well as to the child's GP. Staff could make same-day social services referrals as well as referrals to the paediatric HIV liaison. The UCC had a dedicated child safeguarding liaison nurse.
- A paediatric safeguarding link was available on call at St Thomas' Hospital, who was trained to child protection level three. This person could be contacted when staff in the UCC had concerns about child protection and could provide a rapid referral to the local authority crisis team if needed. The team of ENPs all had been trained to safeguarding level

## Mandatory training

- All ENPs deployed to the UCC were certified in adult and child safeguarding to level three and received an annual refresher. Other mandatory training included infection and prevention control, mental capacity and basic life support. Two dedicated PDNs maintained a training matrix using a trust-wide system that ensured staff were planned to undertake refresher courses in advance. This

# Urgent and emergency services

reduced the risk that training would expire. We looked at training records and saw that all of the nurses who worked in the UCC who were not on maternity leave had 100% compliance with mandatory training.

- Staff we spoke with were very positive about their training, particularly as it was specialised enough to assist them in running the UCC, which was geographically separate from the main ED at St Thomas'. One nurse said, "The training really is fantastic. We [ENPs] feel very confident working here without the direct back-up that we have in the [St Thomas'] A&E. We provide a good service and that's because we're kept really up to date. The trainers and the lead ENP make sure of it."
- Staff working in the UCC received on-going training provided by the lead ENP and practice development nurses. This included annual refresher training in intermediate life support and two-yearly training in paediatric life support.

## Assessing and responding to patient risk

- Reception staffing levels had been modified to meet the needs of the service at peak times of demand. Two receptionists were available at opening time (8am), Monday to Friday, with a third member of staff from 11.30am. On weekends, there was one receptionist from opening time and another from 11.30am. Reception staff and ENPs we talked with told us that they felt this was adequate to stream patients effectively.
- A 'first contact' protocol was in use for when patients first presented in the unit. This was used to activate an escalation process if the patient had symptoms that could not be treated safely in the department, such as chest pain, or if a child under the age of one year old was brought in. The protocol was also used to assess how best to stream each patient and included clear exclusion criteria that would result in a patient being directed to a more appropriate service. Patients with a minor illness were streamed to be seen by a GP and those with minor injuries would be seen by an ENP, who operated on a 'triage and treat' system within 15 minutes of the patient being registered.
- Where a child under the age of one was brought to the department, they would always be seen by an ENP to ensure they were not critically ill before being referred to the appropriate service. If a paediatric patient could be better treated in the paediatric A & E at St Thomas' hospital, an ENP would assess them for the severity of

their condition. If they needed to be transferred, a transfer ambulance or emergency ambulance could be arranged. We saw from looking at a previous incident report that the rapid transfer of seriously unwell children had been arranged and completed quickly and safely once the child had been stabilised.

- Staff used the national early warning score (NEWS) system to assess deteriorating patients and there was a robust escalation policy in place if the patient needed to be admitted to the hospital or transferred to the ED at St Thomas'.
- An on-site crash team was available 24-hours, seven-days a week for patients in cardiac arrest or peri-arrest. All staff in the unit were able to tell us what the procedure was and we saw that this was also displayed in clinical and administration areas.

## Nursing staffing

- A team of ENPs staffed the UCC alongside GPs. The team was led by a member of staff who had developed the ENP role progressively, with a focus on expanding their parameters of practice. For instance, following the successful completion of competency-based assessments, ENPs were able to treat patients who presented with back pain and symptoms of deep vein thrombosis.
- The UCC had one paediatric trained ENP who was also the child safeguarding link nurse.
- Each shift, an ENP was allocated to a triage and treat role, which ensured patients were seen within 15 minutes. In the six months to our inspection, all patients had been seen within this time.
- Staff working in the UCC received on-going training provided by the lead ENP and practice development nurses. This included annual refresher training in intermediate life support and two-yearly training in intermediate paediatric life support.
- As the UCC was staffed by ENPs from St Thomas' hospital, there were no nursing vacancies attributable to this unit and agency nurses were not used.

## Medical staffing

- Medical cover in the UCC was provided by an OOHs GP service operating under a Service Level Agreement (SLA) with the trust. This service is not part of the trust we were inspecting, but we saw that GPs and ENPs worked well together and were providing a service that met the

# Urgent and emergency services

standards set out in the SLA. ENPs we spoke with said that they had a good relationship with the GPs and that there was consistency in the high level of urgent care skills that GPs demonstrated.

- There was a protocol in place for reception staff to escalate situations to the out of hours service urgently, such as if a GP did not turn up for a shift. We were told that this worked well and that problems were very rare.
- Consultant cover was not provided in the UCC. ENPs were able to refer patients to the St Thomas' ED if their condition required consultant input.

## Major incident awareness and training

- Staff had access to the major incident policy and showed us how they would access it. They also explained their responsibilities in a major emergency or evacuation. The policy had last been updated in June 2015.
- All staff had undertaken major incident training with the use of simulation activities and chemical, biological, radiological and nuclear (CBRN) exercises provided by the Metropolitan Police.

## Security

- An on-site security team was based nearby and was available during the unit's opening times. Each member of staff carried a silent alarm that could be activated discreetly to summon help in an urgent situation. The reception desk also had silent panic alarms located at each staff station, which could be used in an emergency.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Effectiveness of the urgent care centre was not rated as the trust had recently taken over as the provider of the service and did not supply any patient outcome data provided that was specific to the UCC. Policies, procedures and protocols reflected best practice from the national guidelines of professional bodies including The Royal College of Nursing & Midwifery (RCN), the College of Emergency Medicine (CEM) and the National Institute for Health and Care Excellence (NICE). This was reflected in the development of the scope of the ENP role, such as their ability to order

X-rays and to treat limb fractures with support from an orthopaedic consultant. Local audits were completed to ensure that abnormal X-rays were referred appropriately and in a timely manner.

The department engaged with the multidisciplinary team at Guy's Hospital, such as radiologists and an orthopaedic consultant. There was also effective working between ENPs and GPs. Despite the two offering a distinctly separate service, staff maintained open communication and were able to support each other. Patients could be referred to additional services, including community outreach programmes that were usually based at St Thomas' Hospital. This meant that people with complex needs could be cared for appropriately, reducing the likelihood of a patient returning with the same problem.

## Evidence-based care and treatment

- ENPs provided care and treatment according to patient group directives, such as ordering X-rays and undertaking knee assessments. There was a good level of communication between ENPs and other specialist teams with regards to such treatment, including with orthopaedic consultants.
- Local audit activity had been conducted by the lead ENP and was often shared with the St Thomas' ED. This had included audits of abnormal X-rays and of medication. An audit of the conditions people had attended the UCC with had led to more robust guidance for reception staff, 111 call handlers and patients about what could and could not be treated in the department. As a result of this signage had also been posted outside of the main hospital to help patients understand what the UCC could help them with. As the unit was staffed by ENPs from St Thomas' ED, local clinical audits were most often completed at that site and any learning applied to practice at the Guys UCC.
- Peer review of abnormal X-ray folders was conducted by the lead ENP. Where poor performance was found to have occurred, this was addressed through a performance management system. For instance, where an abnormal x-ray result had been checked after the patient had left the department, the lead ENP put in place more rigid training for the timely checking and management of results.
- Nurse-led investigations were conducted in-line with NICE guidelines, such as the use of a specialist pathway for the diagnosis and treatment of deep vein thrombosis and the treatment of adults with mental health needs.

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- College of Emergency Medicine (CEM) quality standards were used in the treatment of renal colic, the management of pain, paracetamol overdoses, dislocated shoulders and fracture of neck of femur to benchmark care in the UCC. The UCC did not independently contribute to CEM audits.

## Pain relief

- Patients had access to pain relief after assessment by an ENP or GP.
- We saw that receptionists asked people about pain and that patient records included a pain score.
- We asked three patients if they had been asked about their level of pain when they had been streamed, which they confirmed.

## Nutrition and hydration

- Access to cold drinks was provided in the UCC and there was a nearby hot drink and food outlet open at all times the UCC provided service. We saw that most patients in the UCC were seen quickly and did not need access to substantive nutrition or hydration but ENPs, GPs and reception staff were able to provide additional hydration or order food if needed.

## Patient outcomes

- X-ray facilities were available in the UCC for the diagnosis of fractures. A record of abnormal X-rays was maintained and was checked daily to ensure the appropriate referral of patients to other hospital services.
- Staff contributed to a quarterly 'repeat attenders' meeting where a patient had been seen five or more times in a three-month period. This was conducted by ENPs, the service manager and head of nursing and could include the mental health liaison team where needed. Staff told us that they had few frequent attenders in the UCC due to the majority of patients being local workers and tourists.
- Details of the UCC held by the NHS 111 service were updated regularly to ensure that patients with conditions that could not be treated there were directed to another service. This meant that the most appropriate treatment could be given in a timely manner.
- Children who were known to any of the three local authority child protection teams were automatically flagged as such on the electronic patient record system. This prompted reception and clinical staff to contact

social services before the child was allowed to leave the department. An ENP who worked full time in the UCC was paediatric trained and was a child safeguarding lead and could provide specialist assistance to ensure appropriate care was provided.

## Competent staff

- Thirteen ENPs were certified nurse independent prescribers. Annual audits were conducted through a non-medical prescribing forum and used to ensure that prescribing practices were safe and robust.
- ENPs and reception staff had received an appraisal in the past year. All of the staff we spoke with told us that the appraisal process was positive and focused on their development. We looked at an anonymised sample of nine nurse appraisals and found that they had been completed with professional development as a focal point.
- We looked at the format of appraisals with two PDNs. We found them to be structured on senior nurse developmental pathways and to be motivational in their tone, so as to encourage self-reflection and improved performance.
- ENPs in the UCC had undertaken leadership training and used this to manage the unit effectively, as a distinct service from the main ED at St Thomas'.
- Clinical supervision for ENPs was not provided at Guy's UCC, but staff received this regularly at St Thomas' Hospital.
- An extensive project had been undertaken, following the guidance of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) that enabled nurses to request X-rays. A nurse-requested X-ray protocol was in place and had been ratified by the trust. This required nurses to pass an exam before they could request X-rays.

## Multidisciplinary working

- ENPs and GPs had access to the multi-disciplinary relationships that had been established with the St Thomas' ED. Where a patient needed a referral to a specialist service, this could be provided through St Thomas' and included a mental health liaison team, a homelessness team, an alcohol recovery team and a toxicology consultant.



# Urgent and emergency services

- A relationship had been established with an orthopaedic consultant and on-site radiologists. This ensured that ENPs were able to assess and treat fractures and order X-rays under clinical supervision and in accordance to national guidance, including IRMER.

## Seven-day services

- The UCC operated a seven-day service between the hours of 8am – 8pm. ENP and GP staffing levels were reduced at weekends when demand was typically low. A well-established escalation policy was in place for times of unexpected, exceptional demand at weekends.

## Access to information

- Clinical staff used electronic patient records to access information from other departments in the hospital if they had been treated elsewhere. The results of blood tests and other diagnostic results were also available using electronic patient records, which we saw staff had rapid access to but these could be stored in one of two electronic systems. Reception staff ensured that records were duplicated to both systems after a patient had arrived but there was an initial delay in doing so. This meant that if a patient was seen quickly, the ENP or GP might not be able to access their previous records in a timely manner.
- Staff had access to patient history notes if they had previously been seen at the St Thomas' ED. This helped them to understand complex or challenging behaviour. For instance, if a patient was known to have behaved violently or had specific communication needs, this would be recorded from their last visit. Reception staff also had access to this system. They told us that if a patient arrived and there was evidence that they had previously been abusive or threatening to staff, the lead ENP or GP would be notified to ensure that care and treatment was given appropriately and safely.

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

- There were established procedures for the care and treatment of patients with mental health needs. In most cases, patients would be assessed by an ENP in the UCC, who would then discuss care and treatment options with the mental health liaison team at St Thomas'. Transport could be arranged for patients where this was a safer option for them between the two hospitals.

- We saw that it was routine practice for staff to ask patients for their consent before conducting any assessment or treatment procedures.
- All ENPs had up to date training in mental capacity and consent and were able to tell us in detail how they would provide appropriate care for a patient with a Deprivation of Liberty Safeguards authorisation in place.

## Are urgent and emergency services caring?

Good



The UCC provided a caring and compassionate service to patients. We observed staff treated people with respect and discretion. Staff were particularly skilled at tailoring their communication to the needs of individuals such as tourists who were anxious about receiving medical treatment on holiday. We spoke with three patients who told us that they were happy with the standard of care they had received and they felt staff had a genuine interest in helping them. There were procedures in place to protect staff from the risks of aggressive patients and they had undertaken specialist training that enabled them to de-escalate unpredictable or challenging situations. We spoke with three patients during our inspection.

## Compassionate care

- During our inspection, we saw that ENPs and reception staff spoke to patients with respect and compassion. Receptionists were mindful of the need for discretion and privacy when registering people. A patient we spoke with said, "Yes they're [staff] very aware of how they speak to people here - I felt like they genuinely cared about me this morning."
- ENPs had undertaken a 'The Difference is You' course that was based on the Myers-Briggs Type Indicator, to help staff to respond effectively to each individual and to help relieve their anxiety by building a rapport.

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

- Staff demonstrated good communication skills and had been trained in meeting the needs of patients who were not able to communicate verbally. We saw that staff were able to tailor their communication to the

# Urgent and emergency services

individual needs of people, such as an anxious teenager who was visiting the city and was put at ease quickly by an ENP who understood his concern and was able to build a natural rapport with him.

- ENPs had undertaken conflict awareness and de-escalation training and were able to use this to support people who presented with complex or aggressive behaviour.
- Patients had access to printed information on treatment details for a range of illnesses and injuries. Information was also available to assist people in accessing other services, such as community outreach programmes and the British Red Cross hospital at home service.

## Emotional support

- Staff were able to refer patients to a counselling service on request and on-site psychiatric liaison nurses were able to provide a rapid response visit to the unit if needed. The hospital had a chaplain available, who could be contacted on a patient's request.
- During our observations we saw that staff spoke to patients with empathy and an open, understanding manner. One patient told us, "The staff here have been so kind. It's never nice having to come to hospital but they made me feel much better so quickly."

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

Good



The UCC was a flexible service that was able to respond quickly to changes in demand by deploying extra nursing staff from the main ED at St Thomas' Hospital. The number of patients seen at key times of the day were monitored and this information was used to plan staffing levels for nurses and administrative staff. This ensured that the service consistently met its target of providing nurse-led assessment within 15 minutes of registration.

Complaints were taken seriously and managers used a robust investigation process that was evidence-based to ensure that learning took place.

Patient flow was managed by an effective streaming system that enabled staff at the first point of contact to allocate patients to a GP or ENP pathway. Patients were referred to

other services where appropriate, because the department had a structured exclusion criteria in place for people who presented with conditions that could not safely be treated there.

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

- Demand on the service was monitored monthly by the service manager who was able to work with the lead ENP to schedule nursing staff flexibly. For instance, staffing levels were increased around lunchtime hours Monday to Friday to meet the needs of the local working population who typically used the UCC instead of a GP where they lived.
- When major events were due to take place in the city, staffing levels could be increased to ensure that waiting times were reduced and patients were seen quickly without the need for them to travel outside of the local area. This also ensured that the local resident population could still use the service despite the increase in visitors.

## Meeting people's individual needs

- Staff had a good understanding of the needs of people who presented at the service. The unit is in close proximity to a busy city centre, work district and the service manager told us that weekday lunchtimes could be very busy with city workers who presented with minor illnesses or injuries. On weekends, this demographic often changed to tourists who were visiting the city and who presented with considerable anxiety about accessing urgent healthcare away from home. Staff were well equipped to treat people regardless of their circumstances and we saw that they tailored their communication and approach to reflect this. For instance, a young man on holiday from outside of the UK, attended with an injury. The receptionist showed great respect by speaking with him directly rather than his parents, built a rapport and reduced his anxiety very quickly.
- ENPs had access to a learning disability link nurse who was based at St Thomas' Hospital and could provide advice and support by telephone. Staff were also able to refer patients to outreach service elsewhere in the trust, such as to the homelessness and alcohol recovery teams.
- Printed information in the department for patients was available in a number of different languages and staff had access to a translation and chaperone service.

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- ENP staff had undergone training in dementia awareness and were able to contact a dementia link nurse on the same site if they needed support in providing appropriate care and treatment.
- A children's play box was available to help staff provide distraction or diversion whilst providing triage or treatment.

## Access and flow

- Patients attending the service had increased year-on-year from 2012 to 2015 by over 20%. The service had adapted to this by increasing the coverage of receptionists for initial streaming and by increasing the number of ENPs and GPs available during peak hours.
- The initial streaming process followed a 'triage and treat' model that enabled staff to assign patients to the most appropriate stream for treatment.
- Although the UCC was open until 8pm daily, if it was very busy, the ENP in charge could close the unit to new patients at 7pm. We found this was done rarely and only if staff felt patient treatment would be compromised because of excessive demand on the service. Signs leading to the UCC clearly stated that it could close early due to extreme patient demand and gave information for alternative means of accessing treatment.
- Patients referred to the UCC by the NHS 111 service had their medical details already available in the electronic records system. This reduced the time it took to register them and stream them appropriately.
- In the year to our inspection, the median time to initial assessment was between three and six minutes and the percentage of people who left without being seen was consistently below 3%. A procedure was in place for staff to monitor people who left without being seen, which could also be linked to electronic patient records at St Thomas' Hospital if the patient was a repeat attender.

## Learning from complaints and concerns

- The department had an open and transparent approach to complaints. The complaints procedure was readily available for people to look at and all of the staff we spoke with were able to tell us how they would respond to a complaint. The UCC had not received any formal complaints in the year to our inspection. Staff we spoke with said that the most common minor issue was that patients had misunderstood the scope of the treatment services provided in the unit. We saw that this had been

addressed with a new first contact treatment protocol, improved information for the 111 service to give to patients and new signage outside of the unit and the main hospital entrance.

- Reception staff told us that the streaming process worked very well and that complaints about waiting times were rare. An agency receptionist told us that they had received good training in the handling of complaints.
- The complaints procedure was managed by the lead ENP, service manager and head of nursing. It had been established using best practice guidance from the NHS Litigation Authority and was used to investigate complaints with a focus on future learning as recommended by the Nursing and Midwifery Council. Staff had been trained to say sorry to patients in the first instance.
- Complaints about GP services were monitored by the trust and were investigated alongside senior staff from the out of hours service. We saw evidence that learning had taken place from past complaints.

## Are urgent and emergency services well-led?

Good



All of the staff we spoke with were unreservedly positive about working in the UCC. They told us that the culture was one of integrity and respect and that they felt proud to deliver a consistently high standard of care and treatment.

Governance structures were shared with the trust's main ED at St Thomas' Hospital and included monthly meetings to review incidents, complaints and performance. There was evidence that learning had taken place from monthly governance meetings and that this included improvements in the GP service as well.

There was a focus on development for ENP staff and they were supported and encouraged to complete developmental pathways for progression to the next band. This formed part of a wider positive feeling amongst staff we spoke with who also said that the trust's vision and strategy was coherent and could be used to improve the service.



# Urgent and emergency services

## Vision and strategy for this service

- The trust's 'Shaping our Future Together' strategy was very much a part of the UCC and staff we spoke with were able to tell us how they applied it to their own work. Managers supported staff to develop their understanding of the strategy as well as to explore how they could apply it effectively to their individual role to continue developing their practice.
- Staff were positive about the UCC service and told us that since it had returned to the trust as a service, they felt involved in its direction and success. ENPs said that they were very happy with the structure of the service between them and the GPs and that the head of nursing and service manager were both visible and accessible. Part of the local strategy was led by that of the St Thomas' ED because the nursing team were based there for training and appraisals. We saw that this system worked well and the positive engagement of staff with the ED rebuild was mirrored in the UCC in their enthusiasm and drive to continue the quality of the service as attendances steadily increased.

## Governance, risk management and quality measurement

- Monthly clinical governance meetings took place to discuss incidents, complaints and the scope of the service. Through such meetings, better signage had been provided to let people know that this was not an A&E department and the exclusion criteria for presenting patients had been reviewed.
- The service engaged with the Urgent Care Network to maintain its standards of nurse-led care and treatment as well as to maintain its standards of seeing each patient within 15 minutes of registration.
- Although ENPs worked flexibly between Guy's UCC and St Thomas' Hospital ED, monthly meetings took place for the UCC only. The meetings were used to discuss the operation of the department and we saw that service improvements had been implemented as a result. For instance, an additional band six ENP had been provided on a weekend to help address unexpected periods of increased demand.
- The department maintained a risk register that was managed across the two sites by the head of nursing, clinical lead and the service manager. Nurse staffing levels and the timeliness of the 'triage and treat' facility

were listed for the UCC. We saw that the assigned manager had increased ENP staffing at this site to meet the increasing demands on the service, resulting in the downgrading of the risk.

- There was no written, ratified service level agreement between the hospital and OOHs GP service. This meant that the trust was unable to monitor the efficacy or standard of service provided by GPs because established standards had not been agreed. After our inspection, the trust acknowledged this and issued a plan to establish an agreed service level agreement with OOHs GP service.

## Leadership of service

- Managers from St Thomas' Hospital ED were responsible for this service, including the lead ENP, the service manager and the head of nursing. Each shift had a senior ENP in place and there was a team leader for reception staff to report into.
- The head of nursing and service manager were present on the unit one day per week as a minimum and could increase this if needed. We saw that communication with them when they were off-site was a simple process and staff told us they had never had a problem reaching a senior member of staff when needed. Nursing staff could also contact the lead ENP if he was at St Thomas' and he was able to provide additional leadership support if needed.
- All of the staff we spoke with told us they were happy with the leadership and management of the service. Reception staff told us that the service manager was easy to get in touch with and regularly visited them. They said that levels of support were high and they felt they could work well because they were valued by their manager. ENPs told us that their system of rotating between the UCC and the ED at St Thomas' helped to maintain their skills in both areas. Appraisals and training took into account the differences in patient needs between the two sites and staff said that the leadership support in place helped them to work effectively in the UCC.

## Culture within the service

- All of the staff we spoke with talked openly about the motivational culture of the service, particularly in terms of the opportunities they were given for development. The service encouraged staff to engage with developmental pathways for promotion, particularly

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amongst ENPs. This was particularly evident with band six nurses who were able to engage in leadership practice at weekends, with the support from more senior nurses.

- During our time in the department, we saw staff treated each other with respect and there was a culture of mutual support across all staff roles and grades.

## **Innovation, improvement and sustainability**

- Developmental pathways for ENPs were used to ensure the service was sustainable and led by well-trained, suitably experienced staff. As the UCC relied on ENPs to run one of the streaming pathways, there was a

consistent focus on ensuring their skill base and competencies were appropriate for the patients seen. For instance, band six ENPs from St Thomas' ED were given weekend shifts in the UCC alongside senior nurses to help them develop their practice in nurse-led investigations.

- The implementation of nurse-ordered X-rays and the assessment of limb fractures had enhanced the role of the ENPs and meant that they were able to assess and treat a wider range of conditions, further contributing to service improvement and sustainability.

# Medical care (including older people's care)

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

## Information about the service

The trust's Medical Directorate primarily delivers services at St Thomas' Hospital. The only service belonging to the Medical Directorate delivered at Guy's Hospital is elderly care which provides outpatient/day care services. Other directorates, Abdominal Medicine and Surgery (Renal) and Oncology and Haematology, provide medical services at Guy's Hospital. The information in this service relates to those directorates providing care of medical inpatients at Guy's Hospital.

The hospital has 53 inpatient and 29 day case beds. In the period April 2014 to March 2015, Guy's Hospital admitted 13,422 patients to the hospital of which 23% were nephrology patients.

We inspected the medical oncology and clinical haematology wards (Samaritan Ward and Headley Atkins Ward), nephrology wards (Richard Bright Ward and Patience Ward) and the discharge lounge.

We spoke with 12 patients including their family members and carers, 43 staff members including doctors, nurses, therapists and support staff. We observed interactions between patients and staff, observed the environment and reviewed seven care records. We received comments from our listening event and from people who contacted us to tell us about their experiences.

## Summary of findings

Between April 2014 and March 2015, Guy's Hospital did not meet the Referral to Treatment target (admitted) of 90 % but did so in 88.9% of cases.

There was a positive culture of incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited. There were sufficient doctors and registered nurses on duty, staffing levels were tracked four times a day across the hospital. Patients who were deteriorating were seen by advanced nurse practitioner and had their care re-assessed.

Staff were well supported with access to training, clinical supervision and development. National Institute for Health and Care Excellence guidance was used across a range of conditions. Patients' nutritional needs were assessed with scores recorded and risks identified. Consultants covering oncology and haematology were available seven days per week. Patients were asked for verbal consent to be treated and we saw consent forms to treatment forms had been signed by the patients prior to medical procedures.

Patients received compassionate care and were treated with dignity and respect. Patients and relatives and their relatives were positive about their experience of care and the kindness afforded them. Patients told us they

# Medical care (including older people's care)

were involved in decisions about their care and treatment and were given the right amount of information. The trust had a higher response rate to the Friends and Family test (FFT) than the England average.

We found evidence of monitoring of patient outcomes by directorates providing medical services at Guy's Hospital.

The hospital proactively managed patients discharge. Where a patients discharge was delayed this was escalated to the discharge team to progress. Of the patients admitted 74% (3,444) experienced no ward move and were treated in the correct speciality bed for the entirety of their stay. Patients had their needs assessed and fundamental care rounds were undertaken at different times of the day. Formal complaints were managed through the Patient Advice and Liaison Service (PALS), they were investigated with learning points identified and fed back to staff.

Staff were aware of the trust's vision and incorporated this as part of their daily work. The culture within the division was of openness and honesty. Ward managers were provided with regular reports on incidents, complaints, survey results and staffing data. Trends could be readily identified and learning was disseminated to staff. Staff reported they were supported by their managers and department heads. We found that staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

## Are medical care services safe?

Good



There was a positive culture of incident reporting. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and were supported when they did so. There were processes in place for investigating incidents and there was a range of suitable forums for staff to receive feedback and learning. Rates of harm free care as monitored by the national Safety Thermometer programme were displayed and showed that wards scored between 93% and 100%.

We found that measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited. Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and knew how to access the safeguarding team for advice and guidance when required. Mandatory training helped ensure staff had current knowledge and skills in key safety areas. However, compliance with mandatory training over all for the oncology and haematology was 77% for medical staff, 84% for nursing staff and 88% for allied health professionals. These were less than the trust target of 95%.

We found there were sufficient doctors and registered nurses on duty, staffing levels were tracked four times a day across the hospital. Ward managers would report if their ward was safe or red flag if the staffing level or/skill mix was not as planned. Staff were moved to different wards within acute medicine to ensure that safe staffing levels would be maintained or bank and agency staff would be utilised.

Patients who were deteriorating received a speedy medical response and had their care reassessed. There was a clinical protocol in place for managing and responding to acutely unwell patients. A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The advanced nurse practitioner (ANP) would undertake a full assessment of the patient and commence treatment.

# Medical care (including older people's care)

## Incidents

- There were no never events reported at this hospital. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- It was difficult to ascertain the exact number of incidents which occurred on the medical areas at Guy's Hospital. This is because, the data provided was trust wide and broken down by department/specialty and not by location. We established that between September 2014 and August 2015 508 incidents that occurred in oncology and haematology at Guy's Hospital were reported to the NRLS. Four of these incidents resulted in moderate or severe harm to patients and included patient falls and profound bleeding following a procedure. We did not see any incidents related to nephrology during the above period. Of the five root cause analyses that were provided by the trust, none were related to the medical division at Guy's Hospital.
- Staff we spoke with at all levels were aware that pressure ulcers and falls were the most common incidents. Staff told us they reported incidents through an electronic software system and that feedback was given. A ward matron reported that they encouraged their staff to report incidents regardless of the severity, for example when a doctor did not respond to a night bleep. Staff on the Headley Atkins Ward reported reflection meetings were held which gave staff an opportunity to discuss incidents and share learning.
- We saw examples of where a problem discovered through investigation of an incident had led to a change in practice. For example, some falls with fractures were occurring despite use of 1:1 nursing (usually for patients with agitated delirium and performed by a healthcare assistant). This showed a problem with practice (e.g. high risk patients were left in the toilet by themselves) or support for the health care assistants (HCAs) who were sitting with an agitated patient can be very demanding). This resulted in a series of changes in practice including raising awareness, guidelines and support for the HCA staff.
- Root cause analysis training formed part of the mandatory training programme that was updated yearly. The trust's target was 95% of staff having

completed the training. Within the oncology and haematology directorate, 54% of medical staff, 64% of nursing staff and 88% of allied health professionals had completed the training.

- Monthly morbidity and mortality meetings took place at Guy's Hospital for medical services, where all known mortality cases for the month are presented with brief summaries, cause of death and unit statistics.

## Duty of Candour

- Staff were aware of their responsibilities under Duty of Candour and information was available on the wards. A trust leaflet on the Duty of Candour which was a guide for patients, families and carers gave details of sources of further support was also available.
- A prompt for the Duty of Candour formed part of the datix incident reporting system and required staff to have discussed the incident with the patient or family member before submitting their report.

## Safety thermometer

- Safety thermometer results were recorded monthly. 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. Ward managers collected monthly data as part of the NHS Safety Thermometer scheme. Safety Thermometer and staffing details were displayed at the entrance to all wards in a format that was easily understandable to patients and their families. Key safety information such as days since the last fall, incidence of pressure damage or avoidable infection was displayed at the all the ward entrances. The rates of pressure ulcers, falls and catheter associated urinary tract infections reported via the patient safety thermometer varied and showed no noticeable trends.
- Safety thermometer scores for 'harm free' care for August 2015 showed that the medical wards score between 93% and 96% with Samaritan Ward was scoring 100%. Two of the wards safety boards, Samaritan Ward and Richard Bright Ward, showed that they had achieved over 838 days without a patient falling, with Samaritan Ward achieving 7,326 days. Both wards also recorded in excess of 350 days within out a patient acquiring a pressure ulcer, with Richard Bright Ward achieving 565 days.

# Medical care (including older people's care)

## Cleanliness, infection control and hygiene

- Throughout our visit we found the wards and specialist medical units were clean and tidy. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. We saw that green 'I am clean' labels were in use to indicate that equipment had been cleaned within the last 24 hours.
- Directorates providing care of medical inpatients at Guy's Hospital, reported two MRSA cases between February and March 2015. There were 24 reported clostridium difficile (C Diff) cases between April 2014 and October 2015.
- Adequate hand washing facilities and hand sanitising gel were available for use at the entrance to the wards/clinical areas, within the wards at the entrance to bays and side rooms. There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. We observed that staff generally washed their hands in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene." We saw there were monthly infection control audits; these included an audit of hand hygiene which showed acute medicine achieved 90% or more compliance for the period April 2015 to July 2015.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted all staff adhered to the "bare below the elbows" guidance in the clinical areas.
- We saw clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We observed that staff complied with these arrangements.
- Cleaning audits of the medical wards were undertaken monthly and monitored the cleaning undertaken by different functions within the hospital; these included cleaning undertaken by nursing staff, the cleaners, catering and estates. The audits showed that all but two wards between May and September 2015 achieved 95% all more for cleanliness.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps containers were used appropriately and were dated and signed when brought into use.

- Disposable curtains were used between bed spaces and were labelled with the date they were put up. Staff told us they were changed routinely every three months or sooner if an infectious patient had been cared for within that bed space.
- Infection prevention and control training was part of mandatory training.

## Environment and equipment

- We observed that ward corridors were generally kept clear of equipment, therefore avoiding trip hazards so that people were kept safe. Some wards presented challenges by the nature of their layout. The male bathroom facilities consisted of two toilets, two showers, two small rooms with sinks. There were no en suite facilities in the side rooms. Male patients requiring isolation or who were unable to mobilise to the bathrooms with assistance were offered a commode or bedpan at the bedside until a side room could be sourced as appropriate. Some patients commented that as there were only two toilets, they were not always that clean. Female bathroom facilities consisted of two toilets, two showers, two small rooms with sinks. Three of the side rooms had en suite facilities.
- The medical wards were colour coded so patients living with dementia would be able to recognise the facilities they could use. For example, patients in a blue bay used toilets and showers that had doors painted in the same colour. There were also large illustrations on doors to denote what they were.
- We found each clinical area had resuscitation equipment stored on resuscitation trolleys readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use. This included the recording of daily checks. We noted that checks had been completed and there were no omissions in the records.
- We saw all electrical medical equipment (EME) had a registration label affixed and that they were maintained and serviced in accordance with manufacturer's recommendations. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that they had been inspected and was safe to use.
- Health and safety and fire safety training was part of the statutory training programme that staff were required to attend. The trust's target was 95% of staff having



# Medical care (including older people's care)

completed the training, within the oncology and haematology directorate 91% of medical staff, 99% of nursing staff and 100% of allied health professionals had attended training for health and safety and 58% of medical staff, 71% of nursing staff and 88% of allied health professionals had attended training on fire safety.

## Medicines

- Electronic medical administration records were in place across the acute medicine wards. Staff were required to be logged on to the system when administering medicines. The electronic records recorded the time when patients had their medicine administered, changes to patients prescriptions, and highlighted when a patient could be given further PRN medicines. Medicines that are taken "as needed" are known as PRN medicines. The system flagged when INR tests were needed, if a patient was diabetic or had allergies. Staff also documented on the system, the reason for medicines being omitted or not administered.
- Pharmacists were based on some of the wards and worked on the wards seven days per week, this ensured that the wards maintained their stock levels of medicines. Out of hours, a pharmacist based at St Thomas' Hospital was available via a bleep.
- We observed medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management." Nursing staff were aware of the policies on the administration of controlled drugs.
- Controlled drugs (CDs) were correctly stored in lockable wall units in the treatment room. We saw documentation showing CD stocks were checked daily and that when staff were dispensing the CDs there were two signatures in the CD paper register. When the CDs were administered to the patient, the nurse witnessing had to enter their name and log in on to the electronic medical record.
- Where applicable medicines were stored in dedicated lockable medicine fridges and fridge temperature were checked and recorded on a daily basis and the temperature ranges were within the appropriate range. Stock medicines were stored securely in the treatment room on the wards.
- Patient's medicines were stored securely in lockers next to their beds. Staff had a key code which enabled them

to access the patient medicines when administering. We observed medicines rounds in progress and saw staff checked the identity of patients prior to administering their medicines.

- Medicines to take out (TTOs), were on the wards the day prior to discharge and were stored securely until the patient was discharged. This ensured that patients were not delayed due to TTO's not being available.

## Records

- Electronic patient records were being implemented across the wards which were shared by doctors, nurses and other healthcare professionals. This meant all professionals involved in a patient's care could see the record. Paper records were also maintained which included fluid charts and the patients' care plans. Staff reported they were able to access 24 hour IT support.
- On the wards we saw there was a high number of computers on trolleys and on occasions, there were up to five members of medical, health care and nursing staff, all with computers on trolleys around a patient's bed on a ward round. Ward managers were aware of this and were considering how this could be reduced.
- Medical records were stored securely, staff could only access patient electronic records using log on details and paper records which included patients signed consent forms were stored securely.
- We looked at seven sets of patient records and found that patient notes were completed. Nursing assessments had been completed and care plans were in place. Risk assessments had been completed on admission and reviewed daily and these included pressure ulcer risk assessments within six hours of admission, venous thromboembolism (VTE), nutritional and falls risk assessments. E-notes we looked at were all completed as required and an individual's entry was identified by their log-in details.
- Wards had appropriate arrangements for the disposal of confidential waste.
- Information governance was part of the mandatory training programme that staff were required to attend. The trust's target was 95% of staff having completed the training. Within the oncology and haematology directorate, 68% of medical staff, 70% of nursing staff and 100% of allied health professionals had attended training.

# Medical care (including older people's care)

- We saw documentation audits for oncology, haematology and the dialysis unit for February 2015. These showed 100% compliance with the audit questions of patient details fully completed, staff signature and regular observations recorded.

## Safeguarding

- Staff had access to the trust's safeguarding policy and knew how to access the safeguarding team to access advice and guidance when required. Staff told us this team were very supportive in giving advice and assisting them when concerns were raised or information was required.
- Safeguarding information, including contact numbers for the trust lead were kept on the wards and staff were aware of how to access this. Staff had recently been issued with 'A quick guide to safeguarding' which they could use as a prompt, which covered the different aspects of safeguarding adults and children.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were told examples of concerns they had identified and referrals made. Staff told us they received feedback on the outcome of referrals.
- Safeguarding was part of the mandatory training programme for staff and different levels of training were provided according to the job role. The trust's target was 95% of staff having completed the training. Within the oncology and haematology directorate, 87% of medical staff, 97% of nursing staff and 75% of allied health professionals had attended safeguarding vulnerable adults training. Staff also attended child safeguarding training with 84% of medical staff and 95% of nursing staff having attended level 2 training and 56% of nursing staff and 75% of allied health professionals attended level 3 training.

## Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory and statutory training programme covered basic life support or adults and paediatric, child safeguarding level two and three, equality, diversity and human rights, fire safety, infection prevention, information governance, manual handling, medication management, root cause analysis, safe transfusion, and safeguarding vulnerable adults.

- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed.
- Compliance with mandatory training overall for oncology and haematology was 77% for medical staff, 84% for nursing staff and 88% for allied health professionals less than the trust target of 95%.
  - Basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 95% of nursing staff to have completed the training; within the oncology and haematology directorate, 86% of nursing staff had attended training.
- We did not see mandatory training attendance figures for the nephrology department at Guy's Hospital.

## Assessing and responding to patient risk

- Clinical observations of patients such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The electronic system allowed early warning scores to be automatically calculated within the e-noting electronic record system.
- Staff members had unique log-ins to ensure professional accountability. Temporary staff were allocated log-ins. This meant that recording errors from illegible writing or incorrectly completed charts were virtually eliminated. Staff showed us how the system could be interrogated to show charts and graphs over time, which enabled clinicians to monitor a person's health. The system was accessible from any computer terminal in the trust. The system also had built-in alerts if readings were outside expected parameters, enabling speedy response and re-assessment of care.
- There was a clinical protocol in place for managing and responding to acutely unwell patients and we saw evidence of the appropriate use of NEWS. Staff told us if a patient had a NEWS score of four, they would monitor the patient and use their clinical judgement about escalating. If the NEWS score was five or above the patient NEWS score would be recorded hourly and start a fluid balance chart if not in place, they would call the medical team and the site advanced nurse practitioner (ANP). The ANP will undertake a full assessment of the



# Medical care (including older people's care)

patient and commence treatment and will decide when the patient needs to be reviewed and by whom. An ANP told us "We want to know the minute a patient starts to become unwell".

- At night, deteriorating patients were reviewed by the critical care registrar, who was also supported by an on call consultant (across both sites). The junior doctor was also supported by the site ANP for deteriorating patients and patient step downs.
- AMBER care bundles were in use on oncology and haematology wards for patients who were deteriorating, where their prognosis was uncertain. The AMBER care bundle is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people's wishes.
- Patients were risk assessed in key safety areas using nationally validated tools. For example, we saw the risk of falls was assessed and the risk of pressure damage was assessed using the Waterlow score. We saw risk assessments were reviewed daily and informed the care plans that had been formulated. Risks were communicated to staff using symbols. For example, patients who were at risk of falls had a red signage on the end of their bed and wore red non-slip bed socks. This meant patients who were at a risk of falls were easily identifiable.
- Records showed that patients had been seen on a post-take ward round within 12 hours of admission in line with the London Quality Standards and management plans were in place.

## Nursing staffing

- Vacancy levels for qualified nurses across the oncology and haematology directorate were approximately 12%, which was about 39 whole time equivalents (WTE) and the trust was waiting to fill these posts with newly qualified staff. Wards we visited had differing levels of nursing vacancies. Ward managers told us they had been involved in the recruitment of new staff and had recruited to the majority of posts and were awaiting start dates between now and January 2016. One ward

matron reported they had been able to recruit above their establishment. We did not see data related to the vacancy levels in the nephrology department at Guy's Hospital.

- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited, we saw staffing levels were generally in line with planned staffing levels. Depending on the number of ward nurses, they were either attached to bays or allocated to individual patients. Staffing levels were determined using an acuity tool to determine safe staffing levels. Wards were staffed with a 1:4/5 nurse to patient ratio during the day and 1:6 at night. Ward matrons were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased. Staff that provided one to one support for patients (specials) were not counted in the staffing numbers.
- Staffing levels were tracked at four points during the day as part of the situation report meetings. Ward managers would report if their wards were safe or red flag if staff levels/ skills mix were not as planned. On one ward, staff reported there had been one occasion when staffing levels compromised patients safety as the number on duty was less than planned. This was red flagged and within 20 minutes, the ward had two extra nurses. Ward managers reported staff would be moved to different wards within the acute medicine areas to ensure that safe staffing levels were maintained or bank or agency staff would be utilised.
- Staff reported that handovers occurred twice a day. Staff showed us the printed hand over notes which they updated during the handover. They told us all the patients were discussed, NEWS scores were highlighted and actions outstanding for patients that were due for discharge were allocated.

## Medical staffing

- Consultants represented 36% of the medical workforce in line with the England average of 34%. Middle grade doctors represented 5% in line with an England average of 6%; Registrars 45% which was more than the England average of 39% and Junior doctors 13%, which was much less than the England average of 22%.

# Medical care (including older people's care)

- Each medical ward at Guy's Hospital had middle grade cover/ SpR as well as a rota for consultants on-call. In addition, haematology had an attending system for consultants.
- The average locum rate for oncology and haematology from April 2015 to May 2015 was 3%. This equated to 5.19 WTE consultant/ doctor posts per month. The directorate had the highest locum rate in the hospital.
- At night the oncology and haematology directorate covered their own wards with two junior doctors; Samaritan and Hedley Atkins Wards were covered by an oncology junior doctor and Richard Bright and Patience Wards were covered by a renal junior doctor. Each junior doctor was supported by an on call registrar (based at home, with a 30 minute response time) and a consultant (based at home, with a 30 minute response time). Two consultants were also on call for renal for transplant and renal medical. Doctors reported they felt supported by their consultants and were encouraged to seek support from the on call registrar or consultant if concerned. A doctor gave us an example of them discussing a patient with a consultant overnight and we observed the registrar calling to follow up on the patient at 7.15am.
- Medical staff reported that medical handovers occurred twice a day at 8.30am and 5pm for oncology and haematology. We observed all patients and their treatment plans were discussed with the medical staff coming on shift.
- Medical staff also attended board rounds at 9am which included physiotherapists and occupational therapist with the focus on discharge planning.
- Medical staff reported that their workloads were manageable and that there were sufficient doctors on call during the day and at night.

## Major incident awareness and training

- Major incidents were coordinated via the site control room based at St Thomas' Hospital which operated 24 hours per day 7 days per week. The trust's business continuity plan set out the level of escalation and response required.
- Staff we spoke with were aware that there was a procedure for managing major incidents or an event that impacted on business continuity. On the wards, we saw there was a major incident folder. Staff informed us they would await instruction from their ward manager or the lead site nurse practitioner's (SNP) who covered the site 24/7.

## Are medical care services effective?

Good



Directorates providing care of medical inpatients at Guy's Hospital monitored outcomes for patients and National Institute for Health and Care Excellence (NICE) guidance was used across a range of conditions. Staff had access to clinical policies and guidance on the trust intranet.

Staff were well supported with access to training, clinical supervision and development. Junior doctors told us they felt well supported by the senior medical staff and had access to regular training.

Patients' nutritional needs were assessed with scores recorded and risks identified. Nutrition boards had full details of patient's nutritional needs and preference. Patients were assessed by a dietician when screening suggested a risk of malnutrition. Patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available and drinks were left within easy reach. This meant that patient's nutritional needs were being met.

Consultants covering oncology and haematology were available seven days per week. Wards and specialist medical teams had access to a full range of allied health professionals such as speech and language therapists, dieticians, tissue viability, dementia and diabetic specialist nurses.

Patients were asked for verbal consent to be treated and we saw consent to treatment forms had been signed by the patients prior to medical procedures. Staff we spoke with understood the basic principles of the Mental Capacity Act (MCA) 2005 and could explain how the principles worked in practice. Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was incorporated within staff's mandatory safeguarding training

## Evidence-based care and treatment

- Acute medicine used a combination of NICE and Royal Colleges' guidelines to guide the treatment they provided. For example, the trust's clinical protocol for recognising and responding to acutely unwell patients.

# Medical care (including older people's care)

- Staff understood the NICE guidelines and stated these were referred to in discussions with staff about patients' care and treatment.
- Staff reported clinical policies and guidance were available on the trust intranet. We reviewed some trust policies and judged they were compliant with current guidance and best practice. We noted all local guidance we reviewed were in date and carried a review date.

## Pain relief

- Patients told us they had received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate action to ensure that pain relief was administered in a timely way. The electronic medication administration records indicated when patients could be given further PRN medication which ensured that patients received their medicine at appropriate intervals. Medicines that are taken "as needed" are known as PRN medicines.
- Assessments of patients' pain were included in all routine sets of observations. As part of the "intentional rounding" process (where staff attend patients at set intervals to check a range of patient-centred issues) staff ensured patients were comfortable and recorded this in their records.
- Staff reported they could access the palliative care team and clinical nurse specialists to assist when looking after more complex patients, in order to provide them with support and advice with the pain control of those who were terminally ill.
- We saw a document which indicated that a pain audit was carried with oncology patients, but it was not clear when this was. The audit was related to the management of patient pain on opioids. One of the audit findings was that the initiation of strong opioid generally followed NICE guidelines.

## Nutrition and hydration

- The trust scored similar to the England average for Patient Led Assessments of the Care Environment (PLACE) in the sections on food.
- We observed patients were offered a choice of meals and the menus had been designed to include a range of special diets which included gluten free, soft, vegetarian and healthy eating options. Pictures of the different meals were also available to help patients chose.
- All the wards operated a protected meal time policy. We observed lunch time on one ward and found they were well organised and a variety of food was served. At lunch

time a bell was rung, all activity on the ward stopped and the nurses and ward manager started to serve lunch. Patients who needed no assistance were served first, followed by patients who needed to be observed or assisted with their food. This ensured all the patients had hot meals if necessary and did not have their food left sitting in front of them. At the end of the lunch time, we saw patient's food intake was recorded and monitored.

- Nutrition boards had full details of patient's nutritional needs and preferences. All the wards used the green/blue trays for who needed no assistance, yellow for patients who needed to be watched and red for patients who needed assistance.
- Patients were assessed by a dietician when screening suggested a risk of malnutrition or if there were medical problems that compromised patients' nutrition. Dietary supplements were given to people when prescribed. We saw that fluid thickeners were used as planned. We were advised that nurses would perform swallow assessments and patients would have emergency dietary regimes while awaiting an assessment by a speech and language therapist (SALT). This showed there were systems to ensure people with compromised swallowing received appropriate food and nutrition without delay.
- We observed patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available throughout the day including early in the morning and last thing at night. Drinks were left within reach and patients were given assistance to drink if required. Fluid charts were at the end of patients beds so that nursing staff could record and monitor patients.
- We saw there were adequate arrangements to ensure food safety. For example, we found food service personnel wore suitable PPE, food fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached a safe temperature.

## Patient outcomes

- In terms of outcomes, Renal Medicine submitted to the national renal registry on an annual basis data for renal, dialysis and transplantation services.
- Other audits including the palliative RT for bone metastases found good outcomes for appropriate prescribing; 97.6% compared to 86.6% when they last audited in February 2015. The breast skin cancer audit

# Medical care (including older people's care)

showed good outcomes for patients going home without dressing following radiation treatment and Varicella Zoster Virus serology and vaccination in potential transplant recipients.

- Outcome evidence for new onset of diabetes after transplant found the trust's results were comparable with other programs and that they are diagnosing early. However it found have some limitations in the way the trust conducted the audit which (such as HcA1c not being performed in a systematic manner).
- Between December 2013 and November 2014, the standardised risk of readmission for the medical specialties was 136 which was higher (worse) than the England average of 100 for all elective readmissions. The average for medical oncology was 308 and clinical haematology average was 470 which was higher (worse) than the England average. For all non-elective readmissions the standardised risk of readmission was 121 which was higher (worse) than the England average. Nephrology was 85 which was better than the England average of 100. The average for medical oncology was 116 and clinical haematology was 171 which was higher (worse) than the England average.

## Competent staff

- All new staff received an induction to the trust. The induction programme included the mandatory training staff needed to complete within the first month of working for the trust and key policies and procedures that staff had to familiarise themselves with. Staff reported that they had completed their induction.
- Staff had the appropriate skills and training and their competency was regularly monitored through clinical supervision and the staff appraisal process. The trust reported that 62% of nursing staff within the acute medical services had received an appraisal in the period April 2014 to May 2015 which was less than the trusts target of 95%. As of May 2015, 181 nursing staff required an appraisal. Staff reported that the appraisal process was a positive experience with objectives and targets set. They felt supported by their managers and colleagues and there were opportunities for development and training.
- New nursing staff were able to rotate across different specialties across the trust during their first two years post qualifying. This gave newly qualified staff an opportunity to broaden their experience. On wards,

nursing staff had the opportunity to undertake further training in the speciality they worked; for example in dialysis, continuous ambulatory peritoneal dialysis (CAPD), renal lines and transplants. How

- Nurses told us there were opportunities for learning and development, particularly around enhanced clinical skills training in dementia. Across the trust, 90% of staff had seen 'Barbara's story' which was a video regarding care of a patient living with dementia.
- Nursing staff reported there were workshops to ensure they maintained current registration with the Nursing and Midwifery Council and the appraisal process was moving to a rolling programme throughout the year for the three yearly revalidation.
- In the junior doctors' focus groups we were told they had excellent training opportunities and good supervision from consultants. They were able to work cross-site which meant they were able to gain experience of working in different hospitals. The junior doctors felt workloads were manageable and they felt valued. Junior doctors reported they had weekly teaching sessions and were able to obtain study leave prior to exams. A registrar reported supervision was excellent, they had an hour of teaching each week and had been able to attend between 75%-80% of the training days.
- Consultants reported there were systems in operation regarding revalidation of GMC registration.

## Multidisciplinary working

- We observed one multi-disciplinary board round that was attended by ward by medical staff, nursing staff and therapists. All the patients on the ward were discussed, with information shared about the patient's on going treatment and their nutritional requirements. Patients estimated dates of discharge were discussed and potential issues with discharge were highlighted. Ward rounds were done daily and it was evident there was a multi-disciplinary approach to discharge planning.
- Ward staff had access to the full range of allied health professionals such as speech and language therapists, dieticians, tissue viability, dementia and diabetic nurses and described good, collaborative working practices. Where allied health professionals and specialist medical teams had been involved with patients, this was recorded in the electronic patient records. Medical and

# Medical care (including older people's care)

nursing staff of all grades we spoke with, described excellent working relationships between healthcare professionals. We observed the healthcare team worked well together to provide care to patients.

- Electronic patient records were integrated and shared by doctors, nurses and other healthcare professionals. This meant all members of the team were aware of the input of others, and care was well co-ordinated for patients and their relatives.
- Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good.

## Seven-day services

- Consultant cover was available seven days per week and consultants led daily ward rounds on some of the wards. However, we were not clear whether seven day consultant cover was extended to each medical specialty at Guy's Hospital. There was also seven day cover from registrars and junior doctors.
- Staff reported there was seven day availability of all diagnostic services including imaging and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- Pharmacy services were available at weekends which ensured that patients were able to obtain their discharge medication.
- Speech and language therapists (SALT) provided a weekday service only and nursing staff had been trained to undertake basic SALT assessments during the weekends.

## Access to information

- Clinical staff were able to access electronic patient records from across the hospital using a log in, which meant they were able to access current medical records. Paper records were also available on some wards where electronic paper records had not been rolled out.
- Staff were able to access diagnostic results such as blood results and imaging to support them to care safely for patients. Where patient records were electronic, these were uploaded directly..

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

- Patients told us staff gained their consent before care or treatment was given. We observed a staff member gaining verbal consent by asking a patient if they could

take their blood pressure. We saw consent to treatment forms had been signed by patients prior to medical procedures. Paper copies were retained in the patient records.

- Staff reported that Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was incorporated within their mandatory safeguarding training.
- Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), and told us that they would refer patients to the safeguarding teams if patients required a full MCA. All DoLS applications were also dealt with by the safeguarding team.

## Are medical care services caring?

Good



Patients received compassionate care and were treated with dignity and respect. Patients and their relatives were positive about their experience of care and the kindness afforded them. We observed staff being friendly towards patients and treating them and visitors with understanding and patience. We also saw, and patients told us, that privacy was maintained at all times.

Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Emotional support was provided by staff in their interactions with patients. Most patients were positive about their experience. The trust had a higher than average response rate to the Friends and Family test (FFT) than the England average. On the wards we visited, they had their FFT results for August 2015 on display and saw that the majority were over 89%.

## Compassionate care

- The trust used the Friends and Family test (FFT) to obtain patients' views on whether they would recommend the service to family and friends. We reviewed the FFT scores from the period March 2014 to February 2015; the average response rate for individual wards ranged from 28% to 52%. Overall, they showed satisfaction with the service with the medical wards



# Medical care (including older people's care)

scoring between 76% to 100% during the period. On wards we visited, we saw that they had their FFT results for August 2015 on display and the majority were over 89%.

- We observed interactions between nursing staff and patients were professional, kind and friendly. Several patients told us they thought the nursing staff were "good and caring". Some of the positive comments we received from patients were; "I'm really impressed; they always give you that personal feel", "Despite the nurses being under such pressure they still have a smiley face; that makes it a bit special".
- Patients told us the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given. One patient told us "Staff used a red peg to close the curtains when assisting him so that other staff knew they had to ask to enter."
- Nursing staff reported they would try to ensure patients who were nearing the end of their life were moved to side rooms, which gave patients privacy away from other patients and enabled their families to spend private time with their loved ones.
- Patients we spoke with told us they felt safe in the hospital.
- In the patient led assessments of the care environment (PLACE) the trust scored 93% for privacy, dignity and wellbeing which was better than the national average of 87%.

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

- Patients told us they were involved in their care plan and understood their treatment and care plans. Patients described conversations with the doctors and consultants; they had been able to ask questions and had been told how their illness might improve or progress. Positive comments we received were "Staff are open and honest", "keep me informed as to what's happening, they are very knowledgeable"; "Don't feel kept in the dark", "specialist staff are around to answer questions".
- We observed nurses, doctors and therapist speaking to patients and involving patients in decisions about their care. Patients we spoke with were aware of their estimated date of discharge, what their prognosis was and what arrangements were being put in place for them.

- Relatives we spoke to were happy with the care their relatives received and felt they had been kept involved with their loved ones' treatment. One relative told us "Staff went out of their way to see their loved one as a person and doctors and nurses made an effort to remember to ask about our children".
- Patients were able to access translation services if required and staff knew how to access the support.

## Emotional support

- Patients and their relatives told us the clinical staff were approachable and they could talk to staff about their fears and anxieties..
- A ward manager reported that recently one of the nurses had "gone that extra mile" and made arrangements for a dying patient to see their dog by having it brought to the hospital. The member of staff had been nominated by colleagues and patients won the staff member of the month award.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families

## Are medical care services responsive?

Good



Between April 2014 and March 2015, Guy's Hospital did not meet the Referral to Treatment target (admitted) of 90 % but did so in 88.9% of cases.

The trust proactively managed patients discharge. Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. Situation report meetings operated four times a day to establish where there was bed availability on the wards. Where a patient's discharge was delayed, this was escalated to the discharge team to progress.

Bed moves were coordinated through the site control room. During the period April 2014 to May 2015, 74% (3,444) of patients experienced no ward move and this demonstrated that they were treated in the correct specialty bed for the entirety of their stay. Senior staff reported they would try not to move patients after 6pm .

# Medical care (including older people's care)

Patients had their needs assessed and fundamental care rounds were undertaken at different times of the day. One to one observations were utilised across the medical wards. This meant that patients who had complex needs or who were at risk of falling were supported during the day and night with one to one support.

Formal complaints were managed through the Patient Advice and Liaison Service (PALS); they were investigated with learning points identified and fed back to staff.

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

- The trust was in the process of building a new cancer treatment centre next to the hospital. Staff advised us the oncology wards within the hospital would not be relocated with the new build. Patients we spoke with were disappointed about this, as they felt the wards were cramped and the facilities were not ideal. A senior nurse told us that they may be looking to relocate the ward within the Guy's Hospital site, but no timescale was given for this pending move.
- The patient transport department was located within the discharge lounge to assist with transport arrangements as quickly and efficiently as possible.
- We saw examples of stated visiting hours being varied to accommodate the needs of patients and visitors to accommodate extraordinary circumstances or who were very sick. We saw examples of relatives being supported to stay with a very sick patient during our visit.

## Access and flow

- The Referral to Treatment (RTT) operational standards are that 90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral. Between April 2014 and March 2015, Guy's Hospital met this target in 88.9% of cases.
- Situation report meetings operated four times a day to establish where there was availability on the wards across both of the sites with the two hospitals communicating via video conferencing. We observed the morning meeting at 10am. Ward staff reported the number of discharges planned and the discharges anticipated later in the day of the following day. Where a patient's discharge was delayed, this was escalated to the discharge team to progress.
- The average length of stay for all elective patients was 3.2 days which was better than the England average of

4.5. In nephrology and respiratory physiology it was similar to the England average and for clinical haematology it was worse than the England average. The average length of stay for all non-elective patients was 6.6 days which was similar than the England average. In nephrology and medical oncology it was similar to the England average and for clinical haematology it was better than the England average.

- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records. On wards, designated discharge nurses would oversee patients discharge arrangements. Discharge arrangements were discussed at daily board rounds. Staff reported patients would be given a discharge letter; these were electronically generated and were also sent to the patient's GP.
- To prevent delays with discharge, blood tests were done the night before so consultants had results in the morning and tablets to take out (TTOs) were ordered to arrive on wards the day before the patient was discharged.
- Bed moves for the hospital were coordinated through the site control room. During the period April 2014 to May 2015, 74% (3,444) of patients experienced no ward move, 21% (987) of patients were moved once, 4% (206) of patients were moved twice, 1% (30) patients were moved 3 times and 11 patients were moved four or more times. This demonstrated that 74% of patients were treated in the correct specialty bed for the entirety of their stay. Senior staff reported they would try not to move patients after 6pm of the evening.
- During the period April 2013 to February 2015, the trust exceeded the standards for referral to treatment (RTT) performance for patients starting consultant-led treatment within 18 weeks of referral. Across the medical care services, speciality medicine, general medicine and geriatric medicine, 94% or more patients were admitted for treatment within one month. This was above the England average of 90%.
- At the time of our inspection, 51 patients across the trust were outliers (patients who were under the care of a medical consultant but looked after on a different ward). These patients were seen daily by the medical teams looking after them.
- The hospital had a discharge lounge where patients could wait for transport once they had been discharged from the wards. We saw patients were being offered hot drinks while they were waiting. Staff reported the main

# Medical care (including older people's care)

delay in discharging patients was waiting for the TTOs and this could delay patients by 90 minutes or more. Performance figures were on display for August 2015 which showed 93% of patients left the discharge lounge within 90 minutes of their arrival.

## Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed seven sets of patient records and saw care plans included all identified care needs.
- Fundamental care rounds were undertaken at different times of the day. This recorded when for example, a patient had assistance with personal care or had their bedding changed.
- Patients were issued with non-slip socks, eye masks, and ear plugs to help mitigate noise on the wards at night. Patients who were at risk of falls were offered red bed socks.
- There were arrangements to ensure all patients aged over 75 years were screened for dementia within 72 hours of admission in accordance with current best practice guidance. In May, June and July 2015, over 90% of qualifying patients were screened for dementia.
- Patients living with dementia were identified with a 'forget me not' symbol on ward boards and would be nursed in bays close to the nurses station, in eyesight of staff. The 'This is me' document designed to obtain information to assist staff in providing care to meet the individual's needs of those living with dementia was available on the wards. The dementia and delirium (DaD) team was available to support staff on the wards. There was written information available for staff on how to communicate effectively with people living with dementia.
- On all medical wards, the bays were different colours, in order to assist patients with cognitive impairment. The wards also provided single sex accommodation, with designated male and female facilities close to the single sex bays.
- Patient passports were in use for patients with a learning disability which were completed by their relative or carer. The passports were used so that patients could outline their care needs, preferences and any other information the staff would find useful to assist with their care.
- We also found patients could access a range of specialist services for example specialist nurses in palliative care. The wards also had two psychologists.

These staff offered appropriate support to patients, their families and carers in relation to their psychological and emotional needs. However, we also heard from some patients about the difficulty they had contacting cancer and palliative care services when discharged.

- Patients received information about the ward. This included information on visiting and meal times, what clothes to bring, and discharge arrangements.
- Staff reported they were able to access translation services for patients who first language was not English. Staff could book interpreter services so they could be provided face to face or over the telephone.
- Patients we spoke with were generally satisfied with the quality, range and choice of food that was offered. Food that met people's special cultural and religious needs was available such as halal food.
- Patients told us the wards were flexible about visiting hours and their visitors were able to stay all day. One patient told us that their loved ones were able to stay overnight and that a bed had been set up next to them.
- Side rooms were used to care for patients where a potential infection risk was identified. This could be to protect other patients from the risk or the spread of infection, or to protect patients from infection where they had compromised immunity to infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room.

## Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Staff directed patients to 'Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly and advised them to make a formal complaint. Staff reported that the PALS team recorded all complaints and they would contact the senior nurse or manager via phone and email. The complaint would then be investigated and the complainant would receive feedback with details of the action taken.
- Ward staff reported they received very few formal complaints. Where concerns had been raised, for example with noisy bins on the wards, new, less noisy bins had been provided. Following feedback from patient surveys concerning noise levels at night, patients were provided with ear plugs as part of a welcome pack, so that the impact of the noise at night would be reduced.



# Medical care (including older people's care)

- We noted information on how to raise a concern or complaint was displayed in clinical areas throughout medical care services.

## Are medical care services well-led?

Good



Directorates providing medical services at Guy's Hospital were well led and were rated good.

Staff were aware of the trust vision and incorporated this as part of their daily work. The trust wide vision of 'providing safe productive care' was well known by staff at all levels. Staff showed a positive attitude to their work and spoke well of the organisation and their colleagues. The culture within the division was of openness and honesty.

Ward managers were provided with regular reports on incidents, complaints, survey results and staffing data. Trends could be readily identified and learning was disseminated to staff. Staff understood their role and function within the hospital and how their performance enabled the organisation to achieve its objective.

Staff reported they were supported by their managers and department heads. Senior managers were visible on the wards. Medical staff reported they felt supported by their senior colleagues and opportunities for further development. Staff felt informed and involved with the day to running of the service and its strategic direction.

We found staff and patients were engaged in a variety of ways, and saw examples of innovative practice.

## Vision and strategy for this service

- Staff were aware of the hospital wide vision of 'providing safe productive care'. For staff on the wards, this meant providing the best care possible for patients, making sure that patients were happy with their care, they were safe and comfortable.

## Governance, risk management and quality measurement

- Ward managers were provided with regular reports on incidents that occurred in their areas; complaints, survey results and staffing data. This information was

discussed with the matron who monitored themes and trends. There was monitoring of patient outcomes by directorates providing medical services at Guy's Hospital and NICE guidance informed care and treatment.

- We spoke with the ward managers across all medical services and they detailed the actions taken to monitor patient safety. Staff reported they were encouraged to report incidents and "patient safety was paramount".
- We looked at the risk registers for oncology, haematology and nephrology. They reflected the risks we found. We saw there was a named manager responsible for risk, with details of actions taken to mitigate the risks. The register showed progress was recorded, demonstrating active management of the identified risks.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

## Leadership of service

- Ward staff told us matrons and senior staff were seen on the ward regularly and were approachable and helpful. Ward sisters reported they had a lot of support and felt able to ask for additional support if needed. Other staff reported the director of nursing was seen regularly on the wards. One matron reported that their head of nursing was the "best manager they ever had".
- We saw evidence of nursing numbers and skills mix being reviewed regularly during the day. Staff told us that if they had concerns they would red flag this through to the matron. Staff were moved between wards within acute medicine to ensure nursing levels and the skills mix on the wards were safe.
- Staff told us they felt supported by their line manager to do their jobs; they had clinical supervision and annual appraisals. Psychological support was available to staff on the oncology and haematology wards.
- Leadership at local service level was good. Staff told us they were supported by their managers and department heads. Matrons and heads of departments met regularly. Issues which required escalating were taken forward to the board to be dealt with. Results were communicated back to teams.
- Consultants and medical doctors told us they felt there was excellent communication between medical and nursing staff.
- Junior doctors reported they were supported by senior staff and could work across both hospital sites.

# Medical care (including older people's care)

Consultants assisted with their training and arranged additional training in other medical specialties; for example attendance at respiratory clinics. This gave junior doctors further learning opportunities and experience.

- Development opportunities were available for ward staff. Nursing staff had link roles and undertook different functions on a rotational basis; for example, overseeing the ward discharges and responsibility for patient nutrition. Nursing staff also took responsibility for running the shift and would wear a red arm band to indicate they were the nurse in charge.

## Culture within the service

- Staff reported they were proud to work for the trust; they were enthusiastic about the care and treatment they provided for patients. They described the trust as a good place to work. On the wards, we found some nursing staff had worked on the same ward for more than ten years. Staff commented “some nurses we work with are amazing”, “They make me want to come into work” and “People will find five to ten minutes to discuss things (with you)”.
- Staff described the trust as having an open culture and said they were encouraged to learn. Wards had access to additional funding for training to facilitate this.
- On wards we observed that staff embraced multi-disciplinary working, which involved patients' relatives, therapists and nursing staff working together to achieve the right outcome for patients.
- Patients acknowledged a positive and caring ethos and were happy with their experience of care. Where there were concerns, patients felt able to raise concerns with staff.







## Public and staff engagement

- The trust had various means of engaging with patients and their families. These included various surveys such as the friends and family test and inpatient surveys. In addition, staff reported they regularly canvassed patients to ensure they were happy with the treatment and care they received.
- Staff reported they had regular team meetings. We saw examples of ward staff newsletters which were used to communicate learning from incidents, provide patient feedback and celebrate staff achievements.
- Wards operated a staff recognition programme and during our inspection we saw different examples of staff being named as the “Team member of the month”. Staff were nominated by patients and their peers for having “gone the extra mile”.
- Through our discussions with all grades of staff, staff told us they felt informed and involved with the day to day running of the service.

## Innovation, improvement and sustainability

- The AMBER care bundle was developed through a grant from Guy's and St Thomas' Charity. The Samaritan Ward was the first ward to pilot the AMBER care bundle when it was first introduced.
- Ward staff told us they were aware that the trust was anticipating a deficit for the current financial period. We saw ward managers were looking at innovative ways to encourage staff to think about how they used resources. For example, on one ward, the ward manager had started to collect the used disposable scissors to show staff the excessive amount that were being used and to remind them not to be wasteful.

# Surgery

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

## Information about the service

Guy's Hospital provides a range of day case, elective and emergency surgical services to a national population of patients across a broad range of surgical specialties. 26,513 surgical procedures were carried out in 2014. Guy's Hospital is used mostly for day case and elective surgery, with 16,000 day case procedures, 9,000 elective procedures and 1,600 non-elective procedures in 2014.

There are 19 operating theatres at Guy's Hospital covering orthopaedics, renal, urology, otolaryngology, plastic surgery and general surgery. They operate Monday to Friday 08:00-17:00, with seven day availability for emergency lists, including on weekends. The main post-operative recovery facility has 16 bays. There are approximately 285 inpatient surgical beds in the designated surgical wards.

Surgical activity at Guy's Hospital is managed by five different directorates within the trust: Abdominal Medicine and Surgery (urology, general, colorectal and renal surgery), Cardiovascular Services (cardiac surgery and vascular surgery), Oncology, haematology and cellular pathology (otolaryngology, thoracic surgery), Surgery (plastics and orthopaedics) and Perioperative, critical care and pain (management of theatres). For this inspection we focused on the Surgery, Abdominal Medicine and Surgery, and Perioperative, Critical Care and Pain directorates.

We visited five wards, the surgical admissions lounge, day surgery unit, operating theatres and the recovery area. We spoke with 21 patients and their family members, observed care and treatment and looked at 25 care records. We also

spoke with more than 70 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers, and senior staff. In addition, we reviewed performance information about the trust.

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## Summary of findings

We found good levels of cleanliness, infection control and hygiene across surgery wards and in theatres. Staffing in wards and theatres was good with very low use of bank and agency staff, and there was good retention and management of nursing turnover. There was good completion of mandatory training and effective systems in place to report incidents. However, we found that the sharing of learning from incidents could be improved. We also found some inconsistencies in the application of WHO Surgical Safety Checklist briefings and de-briefings.

Surgical patients received effective care and treatment that met their needs and there was evidence of positive feedback from patients. Their care and treatment was planned and delivered in line with national and local guidelines. Patients were treated with compassion, dignity and respect. All of the patients we spoke with praised the staff for the care they provided and said that they would recommend the hospital and its surgery services.

We found very effective multidisciplinary team working between doctors, nurses, physiotherapists and other allied health professionals. Information was shared proactively between staff groups to ensure good coordination of patient care on wards and to help discharge patients more rapidly. However, this effective team working was sometimes impacted by delays elsewhere in the hospital, particularly in obtaining prescription drugs from the pharmacy.

The leadership and culture of surgery services promoted the delivery of high quality, person-centred care. The service had a clear vision and values. There was high morale amongst staff, particularly on the wards. Staff were supported by their managers and there was a culture of openness to learn and develop services. Performance information was shared within each of the directorates delivering surgical services, but we found limited formal structures for governance information to be shared between the directorates delivering surgical activity. Staff were given opportunities to provide

feedback and inform service development. They were also supported by managers to develop their knowledge and skills to improve the quality of care provided to patients.

# Surgery

## Are surgery services safe?

Requires improvement



We found that safety in surgery requires improvement on the basis of the trust's failure to fully implement the five steps of the World Health Organisation (WHO) Surgical Safety Checklist in theatres. The trust mandated staff to use all five steps, including team briefing and de-briefing components in May 2015. Prior to this, staff were primarily expected to use the three central steps (sign in, time out, sign out) only. We witnessed some surgeons completing the five steps of the WHO checklist thoroughly and in full. However, we also found some inconsistencies in the application of briefings and de-briefings by some surgeons.

Staffing acuity was measured formally twice daily. There was good retention of nursing staff and good management of turnover. Staffing on wards was very good with very low use of bank and agency nurses. There were appropriate consultant cover arrangements in place for nights and weekends. Staffing in theatres was also adequate but nurses reported some pressure to take on extra shifts to fill rota gaps. We found good completion of mandatory training and effective appraisal processes. Doctors in training and trainee nurses were supervised effectively and they reported good access to consultants and senior nurses.

Wards were clean and well organised, and there were effective infection control procedures in place. Equipment sterilisation services were available on site. However, we found limited storage capacity in theatres which could lead to damage or contamination of sterile products.

There were effective structures in place for reporting and responding to incidents, including trend analysis of incidents. Learning from incidents was shared but we found that improvements were required to staff feedback and sharing information between directorates that deliver surgical activity.

Safety thermometer information was monitored, updated and shared appropriately, but there was no uniform approach for displaying these data across the surgical service wards. Patient records were completed

appropriately, but there were some risks associated with the trust's transition from paper-based to electronic notes. Safeguarding processes were well embedded and managed effectively.

## Incidents

- The trust reported nine (one in dental services which we did not inspect) never events between September 2014 and August 2015 across the directorates that delivered surgical activity at both hospital sites. Of the eight included in services we inspected during that period there was one never event at Guy's Hospital which related to a wrong site knee implant. 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. (During the same period there were eight reported serious incidents at Guy's Hospital.).
- Follow up investigations after a wrong site knee implant resulted in an updated care plan, insertion of a pause in theatre processes to check correct site and component, and a new component compatibility check form. However the new process had not been audited or shared for peer review and it was not clear whether it was documented as formal trust policy. Similarly, we did not find evidence that changes were made as a result of another never event where a microvascular clamp was retained after surgery (at Guy's sister hospital: St Thomas' Hospital).
- We reviewed documentary evidence of investigations into never events, including root cause analysis (RCA) reports, which demonstrated an objective and rigorous approach to investigating serious incidents. Senior managers, clinicians and nurses were able to explain the process of investigation and provided examples. We saw evidence of amended protocols and policies which demonstrated that actions from never event and serious incident investigations had been implemented.
- The hospital used an electronic incident reporting system for incident reporting and management. Clinical incidents were reported to the directorate management team of each directorate for investigation and follow-up. Nurses and healthcare assistants we spoke with were aware of the trust's policy for reporting incidents and were encouraged by matrons to report incidents. They also received feedback about subsequent actions and

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learning at ward meetings. We also reviewed minutes of departmental meetings which demonstrated that learning from serious incidents was shared across the service.

- Theatre and ward nurses were aware of the trust's 'Speaking Up' campaign for raising concerns and the trust's use of a daily bulletin newsletter to share information. Clinicians and nurses across the surgery service told us that feedback was shared at ward meetings once per month and was recorded.
- We reviewed documentary evidence such as directorate audit meeting minutes where learning from incidents and outcomes of investigations had been shared with staff. The Clinical Director of Surgery and senior managers within the surgery directorates explained that learning from incidents was shared at monthly directorate meetings, where morbidity and mortality statistics, hot topics and governance data were also discussed. The trust's Risk and Governance Committee also discussed and shared learning from never events and serious incidents.
- Senior managers and clinical governance managers reported close links between the hospital directorates that had surgical activity. However, we found limited evidence of formal channels where learning from incidents could be shared across the directorates. For instance, heads of nursing, general managers and clinical directors from each directorate met on a quarterly basis to discuss never events and serious incidents, but this meeting had only just been set up. Its first meeting took place in September 2015, just before the time of our inspection. Senior managers also told us that a theatre users' group was the usual avenue for staff across surgery directorates to discuss theatre activity but this did not cover never events, serious untoward incidents or learning from incidents.
- There was recognition amongst senior managers of the need for more opportunities for formal and informal discussions between counterparts within each surgical directorate and a need to improve how staff take back learning to their respective teams.
- Senior service managers also told us that there was a need for more sharing of incident investigations and outcomes with staff in wards to 'close the feedback loop'. Training and drop-in sessions for staff were introduced in early September 2015.

- Clinical governance managers highlighted incident trends of medication administration and prescribing errors (storage of controlled drugs and prescribing controlled drugs for discharge), patient falls and appointments access and discharge.

## Duty of Candour

- There was good understanding of Duty of Candour. Staff we spoke to in theatres and on wards were able to explain what duty of candour means and how it could be applied. For example, nurses told us that if a wrong medication was given to a patient, then the patient would be informed.

## Safety thermometer

- We found that safety thermometer information was displayed prominently in each of the surgery wards we inspected. 'How are we doing' boards and 'Safe in Our Hands' posters in these wards displayed safety thermometer data such as hand hygiene audit statistics, number of days without a pressure ulcer, number of days without a patient fall, and friends and family test scores.
- The safety thermometer measurement was conducted in the middle week of each month. All ward areas measured catheter urinary tract infections, new catheters, pressure ulcers, falls with harm, and new venous thromboembolism (VTE).
- Safety thermometer outcomes were published on the trust website, reported to the multi-disciplinary board meetings and to the chief nurse's office. The trust had a lead nurse for safety thermometer who reviewed all submissions. If there were increases in key areas such as falls with harm or UTIs there were ward-based working groups to support staff with on the job teaching.
- We found that safety thermometer information was displayed differently in each ward. Senior managers told us that the display of safety thermometer information was delegated to each ward to decide what they displayed. There was no uniform approach across wards for surgery patients. Ward managers felt that this allowed them to show more relevant information for their particular specialties. General managers and heads of nursing told us that the trust was moving away from a culture of displaying lots of data for the sake of it as they believed more relevant information was of greater benefit to patients.
- The hospital's pressure ulcer prevention management pathway was in line with National Institute for Health



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and Care Excellence (NICE) guidelines. Hourly rounds helped prevent pressure ulcers by turning patients who were at risk and re-arranging pillows and pads. A Urinary Catheter Care Passport was in place to assist patients with their catheter maintenance. Heads of nursing told us they had high numbers of catheters but low numbers of infections. Patients were rarely discharged with catheters. We were told that spinal patients were discharged with urinary catheters in place. VTE risk assessments were conducted and audited appropriately.

## Cleanliness, infection control and hygiene

- The most recent Surgery Infection and Prevention Control (IPC) scorecard reported zero incidents of blood infections or C. Difficile (May- June 2015).
- In theatres, surgical site infection rates were monitored by an infection prevention and control team and patients were prepared for surgery in accordance with NICE guidelines (CG74). All elective patients were assessed for MRSA before their procedure. If a patient was known to have C.Difficile their care management was changed accordingly, such as position on the operating list and decontamination of theatre. There were five IPC liaison nurses in theatres who had completed infection prevention and control training.
- Waste segregation, storage and disposal was managed in line with Department of Health guidance.
- The hospital's infection prevention and control policy was in line with Infection Prevention Society guidelines and we observed that personal protective equipment was available to staff, appropriate to each service area.
- We witnessed hand hygiene processes being followed by staff on wards. Gloves and plastic covers were available at the entrance to each of the wards. Alcohol gel was not available outside of wards due to previous theft and misuse.
- Cleaning staff were photographed and named on the cleaners' ward noticeboard alongside their job specification and daily and weekly cleaning schedule. This detailed cleaning duties such as dusting surfaces, cleaning glass doors, mopping floors and cleaning bed frames. It also identified which cleaners were responsible for which areas of the ward such as specific bays and beds.
- Hand hygiene and isolation audit results for August 2015 were displayed on information boards in the wards and showed 100% compliance. Trust data from April-June 2015 also demonstrated 100% compliance. However, while on the wards we observed two members of staff that were not bare below the elbows. In theatres bare below the elbow was largely observed.
- Monthly hand hygiene and isolation audits were completed by IPC link practitioners throughout the surgical specialties. Service managers reported that infection prevention and control audit outcomes were presented at multidisciplinary board meetings.
- Cleaning issues were also picked up in real time and escalated to cleaners as necessary. Cleaners were organised as part of ward teams and interacted with ward staff and patients.
- Toilet and washing facilities in wards were witnessed to be clean. There were adequate numbers of toilets and washing facilities for patients with mobility challenges.
- Sluices in wards were witnessed to be clean, tidy and well organised. They were not used for storage and contained only sanitation products. Control of substances hazardous to health (COSHH) and health and safety posters were on the walls in the sluice and around the wards we visited.
- The food preparation area in wards was located by the main door to each ward we visited. Each of these rooms was clean and well organised.
- Senior nurses told us that medical outliers placed on surgical wards were allocated to a separate bay with separate toilet and washing facilities to prevent cross-contamination of infection. Patients were screened for MRSA during their pre-operative assessment, but three side rooms with individual beds were used in each ward for those patients not yet tested for infections. However this was reported as one of the main challenges on Sarah and Queen wards. Of four side rooms in each ward, only one had independent toilet facilities which meant that three of these rooms could not be used for true isolation purposes. The ward managers were investigating ways to create more independent toilet facilities and used dedicated commodes for patients requiring isolation.
- Theatres were clean, tidy and well organised but the general environment of theatre facility appeared dated and some parts were being refurbished.
- There was an onsite sterilisation service for theatres and wards to sanitise instruments, endoscopes, pumps and mattresses. However, we observed some challenges with storage capacity in theatres and found sterile

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equipment and sets stored in non-sterile theatre corridors. Theatre sluice and endoscopy wash facilities were also used for storage which could lead to contamination.

- Surgical site infection rates (SSI) for 11 surgical specialties were continuously monitored by the trust and reported using Public Health England protocols. The trust's SSI audit demonstrated a significant fall in the number of SSIs between 2009 and 2015, and Guy's Hospital was performing in line with national averages with approximately 0.05% of all procedures experiencing an SSI.

## Environment and equipment

- Equipment on resuscitation trollies was organised and clean and records of checks and usage were current and updated daily. However, the resuscitation trolley on the main theatre corridor had some open but unused endotracheal intubation tubes and bougies (a thin cylinder of plastic, metal or other material) which were no longer sterile. We raised this with the theatre matron and they were removed immediately.
- We found extensive use of mobile computer stations throughout the wards which were used by clinicians and nurses to review and update patient notes on the e-notes system. There were adequate numbers of stations for nurses to use on all of the wards we visited. Nurses and senior staff told us that extensive training and support had been provided to use these systems.
- We found that larger equipment such as weighing scales and support apparatus were stored in recesses at the end of ward corridors. All equipment we checked was clean and had up to date 'I am clean' stickers to demonstrate that they had been sanitised.
- All of the wards we visited were well organised, clean and well lit. The wards provided a relatively calm and peaceful environment, with adequate provisions for privacy. However, some of the patients we spoke to reported that wards were noisy at night which made it difficult to rest or sleep properly.
- A 'walk around' of wards was carried out by the hospital's estates team on a quarterly basis which included picking up on issues such as dents, knocks and holes in walls.

- There was an initiative called the Excellent Ward Project that incorporated IT services, estates and facilities. The initiative was designed to improve the system of repairs across the trust. A repair/handyman visited each ward and clinical area weekly to pick up any required repairs.
- Consultant and trainee surgeons reported that they had sufficient equipment in theatres. We were told that orthopaedic surgeons had rationalised prostheses for 80% of cases with allowance for 20% special causes and trials.
- We found that both the Surgical Admissions Lounge (SAL) and Day Surgery Unit (DSU) within the hospital were too small to effectively manage the workload and increased daily patient throughput. The SAL was inadequate for the task as it was too small, with inadequate privacy and inability to manage patients with limited mobility or other medical conditions such as diabetes. In the DSU there was no secondary recovery area for patients that needed to stay several hours where they could rest on a trolley bed. Instead they had to stay in the primary recovery areas.

## Medicines

- The controlled drugs rooms in theatres and on wards were accessed by a secure entry key card system, which recorded who entered the room. Controlled drugs were stored in a locked cupboard within these rooms, and the nurse in charge was responsible for holding the key. Non-controlled drugs were stored in Omnicell cabinets in these rooms. The cabinets were stocked by the Omnicell team, usually at night. This incorporated fingerprint and pin code security access for staff members to open the cabinet. Staff select the required medication, and then press the button on the shelf where the medication is stored which records when the item is removed.
- Drug fridge temperatures were monitored and recorded appropriately in line with national guidance. We checked a sample of fridge temperatures and all were within the acceptable range.
- Usage of controlled drugs was checked twice daily at handover and this was reported at handover. The controlled drugs records we reviewed were completed appropriately and in full.

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- We checked the emergency drugs on resuscitation trolleys. Drugs were within date and there was a process for checking and ensuring that drugs were updated before they expired. Controlled drugs for resuscitation were kept securely in a locked box.

## Records

- Patients were risk assessed on admission, including Waterlow score, VTE assessment and identification of tissue viability. All elective surgical patients undergo a pre-op assessment in the DSU and inpatient theatre. Emergency cases going onto elective lists were assessed on admission in the DSU. The admissions documentation we reviewed was fully completed.
- A large white board located opposite the main nurse station was used as a patient information board in each of the wards we visited. Nurses used a coloured magnet system to identify the key components of care for each patient including length of stay, continuing care needs and planned discharge dates. There were sections that identified physiotherapy and OT input and need. There were sections to identify whether VTE and MRSA had been assessed. There was also a measure of each patient's acuity.
- The hospital was moving from a paper-based to electronic notes system. E-noting was first introduced in April 2014 and ward managers told us this was still in a transition phase. In practice this meant that there were multiple places that patient information was located. At the time of our inspection, e-notes was not fully implemented for the surgery wards we visited and some patient charts were still recorded on paper notes. The surgery directorates were monitoring the risks of using two concurrent systems and departmental risk registers highlighted that this was being managed appropriately. Theatres used hand written paper notes only and were not on the electronic system. There was no electronic anaesthetic record in DSU or inpatient theatre.
- Ward managers demonstrated how the e-noting system worked and how information was recorded and retrieved on the system. Assessments were found as standard and included Waterlow scores, BMI, social assessments, MRSA history, National Early Warning Score (NEWS), a daily living activity assessment and a discharge checklist. NEWS automatically calculated a score and high scores were flagged to the senior nurse. NEWS scores were communicated to ward staff in

morning handover where follow-up actions were also reported. We were shown an example of a patient's NEWS score 'spiking'. Records showed they had been reviewed by a trainee doctor within 12 hours.

- Another assessment showed 'fundamental care'. Bathing, pressure areas, hair, glasses, oral hygiene, hearing aid, shaving, nails, legs (TED stockings) bed safety and clothing were all part of this daily review.
- Where electronic notes were available, we found that the system worked effectively for the most part, however, nurses told us that sometimes they cannot enter observations contemporaneously as they were unable to open the relevant 'page' because it would not load.
- Managers told us that staff had provided feedback on the e-notes system and that changes were made as a result. Initially for e-prescribing the training was not adequate and this was subsequently modified. Nurses reported a focus on ward-based training for e-notes in an applied setting to make the training more relevant.
- We checked a sample of paper patient 25 records on each ward and found that they were completed, legible and up to date. Paper notes were stored in safe, visible note trolleys by the nurses' station.
- Fluid balance charts were checked and these had all been completed. Paper notes were used to record if and when nurses had encouraged patients to drink more water. However, in the sample we reviewed, the total at the end of each day was not always calculated to complete the daily review of fluid balances.
- In theatres, operating theatre registers were audited for completeness and all patient documentation were completed and included in clinical records. This included swab and instrument counts, implant details (where used), and consumable bar codes.

## Safeguarding

- Safeguarding referrals were completed on line and were reported directly to the hospital's safeguarding office. Ward managers told us they were happy with the speed of response and would usually receive a follow-up call within hours of the referral. There were separate safeguarding teams for adults and children.
- Adult and children safeguarding training was provided to all new staff as part of their corporate trust-wide induction. Safeguarding was part of mandatory training

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and more than 85% of staff within the surgery directorates had completed their training. The trust did not provide completion rates for each of the different staff groups.

- Safeguarding information was also available for staff on the trust intranet and there was a booklet staff could refer to. All of the clinical and nursing staff we spoke to were able to detail different types of abuse and safeguarding concerns and how to report it.
- General Managers told us that the hospital safeguarding team helped ward staff if they had doubts or concerns about implementing safeguarding policy. Nursing staff conducted formal safeguarding assessments but they were encouraged to contact the safeguarding team if they were concerned about a potential safeguarding trigger. Managers reported that the majority of safeguarding concerns in surgery were for elderly patients from care homes.
- We found good awareness of Female Genital Mutilation (FGM) amongst staff. Nurses told us that FGM awareness was incorporated in annual mandatory safeguarding training and in trust-wide induction. There was a Royal College of Nursing protocol in use for reporting FGM. A midwife within the trust was also involved in developing FGM policy nationally.

## Mandatory training

- Senior nurses and managers told us that compliance, completion, review and renewal rates for mandatory training were monitored using the trust's 'Wired' computer software. Completion of mandatory training was required as a component in all staff annual appraisals. Business partners from the trust's human resources department supported directorate managers with monthly reports on completion of mandatory training and this was discussed at monthly MDT meetings. Managers received reports of training compliance expiry dates for each member of staff and reminders were sent to all staff. Managers told us that bank and agency staff are required to be compliant with all mandatory training or they are 'frozen' from the system and not used.
- Mandatory training rates for surgery wards for the months preceding our inspection were within the range of 85 -100%, but improvements were required for safe transfusion competency, which in some wards was recorded at 25% completion rate.

- Conflict resolution training was added to the list of mandatory training modules for nurses following feedback they needed improved capability and awareness.
- There was a comprehensive induction programme for newly qualified nurses, including a two day trust-wide corporate induction and a three day nurse specific induction which included ward orientation and interactive observations on drugs knowledge and calculations. There were induction checklists for agency and bank nurses on wards and in theatres.
- There was a comprehensive induction programme for doctors in training. Doctors in training reported effective orientation processes, access to mandatory training and regular teaching sessions.

## Assessing and responding to patient risk

- National Early Warning Score (NEWS) charts and scoring system were used and recorded in patient notes and there was an escalation protocol for high warning scores. This information was recorded on e-notes. Changes to NEWS were discussed by clinicians and nurses during handover and action was taken accordingly. General managers told us that recording and escalation of early warning scores was audited by sisters. Sisters monitored charts of each patient each day and the heads of nursing and matrons sampled a snap shots of charts. If nurses had concerns or needed help then support was available from site nurse practitioners who were responsible for critical care should a patient present high warning scores.
- Acuity was measured twice daily, once during the day and again at night. Alerts were shared with matrons, but matrons told us that they were usually aware of any concerns before acuity was escalated. Matrons told us that staffing levels on the wards were adjusted if acuity rose within a particular ward to ensure adequate cover.
- We found appropriate processes for ensuring the effective care of medical outlier patients with high acuity on surgery wards. The needs of non-surgical patients were discussed by ward managers and matrons and appropriately skilled nurses from the medical directorate were brought into the surgery wards when needed.
- An escalation process was in place in the recovery area if a patient suddenly deteriorated and the recovery nursing staff were aware of this process. Nurses received training in recognising a deteriorating patient.

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## Use of five steps to safer surgery

- The World Health Organisation (WHO) Surgical Safety Checklist was used in theatres. The trust introduced the three central steps (sign in, time out, sign out) in 2010 and in May 2015 mandated the use of all five steps to include team briefing and de-briefing components. We witnessed some surgeons completing the five steps of the WHO checklist thoroughly and in full. However, we also found some inconsistencies in the application of briefings and de-briefings by some surgeons. We saw documentary evidence and were told by matrons and clinicians that the service had recently 'relaunched' its approach to the safer surgery checklist, but de-briefings were not fully embedded and its implementation was incomplete. The trust was aware of this and documentation from the Quality and Performance Committee demonstrated that further work was planned to ensure it was fully implemented.
- WHO checklist audits were conducted every six months. An audit was conducted in August 2015 and the hospital was monitoring progress against actions. The audit reviewed 513 procedures and 186 separate surgical teams covering 20 specialties. All three compulsory stages of the checklist were completed at the appropriate time in 90% of cases. An increase of 9% compared to 81% in the February 2015 audit. This was the highest observed compliance since the checklist was introduced. In 100% cases observed, at least one stage of the checklist was carried out. 9 out of 20 specialties were 100% compliant with completion of the checklist.
- The audit noted good engagement of nursing staff in the checklist, with nurses leading the three compulsory stages more frequently than other staff groups.
- The August 2015 audit report noted improvements to the overall compliance rate with each of the three compulsory stages at over 95%. Compliance with sign in and sign out increased, but overall compliance with time out reduced slightly from 98% to 96%.
- Team briefings were completed but theatre staff told us that the consultant in charge of the list was not always in attendance at the start of the briefing and responsibility was sometimes delegated to a doctor in training or Fellow. We also observed that debriefings after a procedure were not routine and not entirely accepted as necessary, particularly by some consultant surgeons.

- We were informed of a recent retention of a clamp in the day surgery unit, which was the subject of a root cause analysis. The investigation found that the surgical count was not performed correctly and recommended further reinforcing and 'tightening' of the WHO checklist.
- In the day surgery unit we observed a 'time-out' pause which although reasonably conducted, did not include the scrub nurse or theatre runner as they were setting up their trolley in the preparation room. This was not registered by the team doing the checklist at the time. Two sets of notes were inspected in the recovery area and in both sets the sign in and sign out had been completed and signed for but not the 'time out'.

## Nursing staffing

- We found adequate nurse staffing levels and retention in wards and in theatres. Nurse staffing requirements were identified according to NICE guidance, using patient acuity level data. Staffing records documented low vacancy rates and infrequent use of agency nursing staff. Ward managers showed us the 'inpatient nursing safe staffing sheet' which was used as an acuity tool. We were told that each ward had a staffing ratio based on acuity. The 'Integrated Patient Acuity Monitoring System' (iPAMS) was in use and was completed twice in every 24 hours (day and night). Planned and actual staffing numbers were recorded. Patient acuity was measured at the same time on a different system using category levels 0, 1a, 1b, 2 and 3. This was reviewed on a daily basis by matrons and ward managers. If the complexity or acuity of a ward increased, the ward manager told us they discussed support requirements and staffing needs with the matron. Measures could include reallocating a nurse or healthcare assistant from their 'buddy' ward or taking lower acuity patient admissions to the ward.
- Ward managers and matrons told us they could usually fill vacant shifts with bank staff from their own wards (those nurses wanting to do extra shifts) and could also call on their 'buddy' wards for temporary re-allocation of nurses. Staff were shared between buddy wards as required and nurses in these wards received the same induction and appraisal processes so that they could work across both wards. A ward manager told us of a post-operative mental health patient who had been admitted to their ward and that they had received adequate support during their admission.
- General managers reported that usage of bank and agency nurses is reported weekly by ward sisters to the



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respective head of nursing. A monthly performance report was also sent to the head of nursing of each directorate, containing statistics on the amount of bank, agency and sickness hours for their respective wards. Heads of nursing discussed staffing with sisters weekly and staffing statistics were escalated to the trust's executive team via PRM. We saw reports for the Surgery directorate from the previous month (August 2015) which showed 174 bank hours, 237 agency hours, 207 nurse sickness and 149 nursing assistant sickness hours.

- Agency nursing hours were accounted for through the use of long term agency nurses contracted to a ward for three months at a time. This allowed for consistency of practice and familiarity of trust and ward procedures.
- Senior managers across surgery directorates demonstrated a strategic approach to nursing recruitment and proactive planning of staffing needs. The trust maintained rolling adverts to recruit nurses and ensured a quick turnaround if applicants were successful at interview. Successful applicants were offered a position on the day of their interview. However we were told that urology and general surgery wards had experienced some challenges in recruiting suitable nursing staff.
- Matrons and senior managers reported good conversion of student nurses to substantive posts and this supported on going recruitment needs. Guy's Hospital surgery wards received positive feedback from student nurses on placements.
- Meetings were held every Monday to address capacity and plan staffing for each ward, and to prioritise patients for the week ahead. Ward managers told us that this gives them a good indication of the skill mix needed on each ward.
- Capacity and skill mix requirements for theatres was discussed at weekly theatre MDT meetings but surgeons did not attend this meeting. Senior theatre nurses reported that training pathways were available to nurses to enable multi-skilled deployment across theatres, anaesthesia and recovery.
- We observed close working and support between ward managers in buddy wards. Ward managers also reported good access and support from matrons.
- We spoke with a regular patient on the orthopaedic ward who told us that wards did not use many locum or agency staff this meant they had been cared for by familiar faces, which they found reassuring.

- We found effective handover arrangements in place on the wards we visited. Nursing handover was at 07:30 and 19:30 each day, with a clinical handover held at the nurse station to review patient medcharts, wounds and important clinical matters. This was followed by a bedside handover which reviewed all patients' NEWS scores, e-notes and medchart. The nurse in charge attended the doctors' handover to ensure information was shared between different staff groups. Nurses and clinicians told us that handover worked well and was well organised. Team briefing meetings were held before each handover where major clinical and corporate information was shared, for example, the introduction of new catheter passports. Newly qualified nurses told us that handover provided good learning opportunities because they discuss protocols for different patients.
- Nurses in theatres and on wards told us that management of rosters could be improved. Ward nurses told us that they may be required to work inconsistent shift patterns, such as four consecutive shifts in one week and then two shifts the next. Theatre nurses also told us that they were pressured to take on extra shifts to cover gaps in the rota and that they had some short notice shift changes to cover gaps.
- Theatre nurses also told us there were frequent over-runs of theatre activity, which meant that they often had to stay up to two hours beyond their shift time. Although nurses received this time back as time in lieu, they perceived that more nursing staff were required to meet the demand in theatres and that the service frequently relied on the good will of staff to take on extra work or stay late.

## Surgical staffing

- We found adequate surgical staffing levels comparable with national averages. At the time of our inspection there were 525 medical staff members employed in surgery across the trust. This comprised 40% consultants, 48% higher level trainees, 10% junior trainees and 2% middle grade.
- We found appropriate arrangements in place to ensure out of hours cover at nights and weekends. There was 24 hour consultant cover with support from core and higher doctors in training. Consultants, doctors in training, theatre staff, matrons and ward managers reported adequate cover at night and at weekends.



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Higher specialty doctors in training (at ST3 level or above) were resident at night and consultants were on call during out of hours. Consultants and registrars shared weekend cover.

- Senior managers reported infrequent use of locum doctors across surgical directorates.
- Daily ward rounds were consultant led. We observed adequate presence and input by consultants and doctors in training at handover and ward rounds. Theatre handover occurred at 07:30 and 20:30 each day.
- Doctors in training did not identify problems with their rotas.
- Clinical leaders within the surgery service highlighted the impact of recent changes to the surgery training post allocations in London. Guy's Hospital is the orthopaedic surgery lead training provider for Health Education South London but national reductions to the allocation of surgery training posts had resulted in eight fewer Foundation Doctor allocations for 2015/16. The surgery service had introduced a new structure with specialty trainees and physician assistants filling gaps previously held by Foundation Doctors.
- At the time of our inspection, the Orthopaedic unit had appointed five physician assistants and several nurse practitioners to support clinicians and manage service delivery. One had recently started in post and matrons told us that supporting and setting up the associates was a priority but also challenging because it was a new role. However, clinical leaders recognised that the on going reduction in surgery training posts would require further changes to service provision in the long term. The clinical directors we spoke to planned to double the number of physician assistants.

## Major incident awareness and training

- Staff in wards and theatres were able to explain the trust's major incident plan. Staff on wards showed us the protocol document which was available in the wards by the nurses' station. Nurses were able to give examples of when alerts had been put in place.
- General managers received control room training to improve awareness of major incident management. Senior staff also received training in business continuity planning. Each service was required to prepare a continuity plan by the trust's emergency preparedness team. An interactive major incident exercise was

conducted in May 2015 involving multiple partner and community organisations. This was supported by a follow-up report which identified areas for improvement.

- Doctors in training and theatre staff were also aware of major incident plans involving other trusts but there were some gaps in their knowledge and detail of how it works. They explained that they would seek guidance from their respective managers if the situation required it.

## Are surgery services effective?

Good



The surgery service at Guy's Hospital surgery was effective. We found a highly effective approach to multi-disciplinary team (MDT) working, with good coordination and input by different practitioners, from pre-assessment through to post-operative care. We found genuine six day working in theatres and the hospital is actively working to open theatres on Sundays and increase the number of day case procedures. Routine data collection for day surgery cases could be improved as it was not clear who was responsible for this.

There were clear structures for ensuring the implementation of best practice surgery guidelines. Patient outcomes were comparable with the England averages, and action was being taken to reduce length of stay across surgical specialties. Nutrition, hydration and pain relief were managed effectively. The hospital provided good opportunities for staff development including access to training and leadership experience for nurses.

## Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet pages. Each policy identified when it was produced and last updated. Printed copies of relevant policies were available for staff to reference at nurse stations in wards.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines. The trust's policy for recognition of and response to acute illness in adults in surgery services was provided in line with NICE CG50 guidance (see Assessing and responding to patient risk in safe

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section) and post-operative rehabilitation services were provided in line with NICE CG83 guidance (see sections on Guy's Orthopaedic Outreach Team (GOOT) and Proactive Care of Older People (POPS) services).

- Surgical protocols were produced locally within directorates with multidisciplinary input from specialist nurses, clinicians and referenced current national guidance. Approval, control and management of these protocols was coordinated by a dedicated central team within the trust. New local policies and best practice guidance was ratified at monthly MDT boards. A dedicated trust forum monitored compliance with NICE guidance, and compliance was included as a standing item on the clinical governance meeting agenda for the surgery directorates. The central team sent out forms to each directorate to monitor compliance and submitted this information to NICE. The clinical governance team shared circulated new NICE guidelines with clinical and nursing staff on a monthly basis and facilitated implementation of new guidance with clinical leads.
- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance. Service managers managed outcomes teams which were responsible for the data entry to national audits and registries.
- Local audit activity was mostly effective. Standard audits such as monthly hand hygiene and sharps audits were conducted, and WHO checklist audits were conducted every six months. However, service managers reported some challenge with local audit, highlighting that Consultants were dissatisfied with the management of clinical audits by doctors in training. They found that some audit processes were not applied appropriately and some audits were not completed by the time a training placement had ended.
- The surgery service contributed to the hospital's Falls Improvement Group (FIG) which examined patient fall details, aggregated data and identified trends in falls. From these data, the FIG identified a need to mobilise post-operative patients at a slower pace, and this resulted in a reduction in the number of falls.
- All staff were required to complete equality and diversity awareness training during their induction to ensure that patients, staff members and the public were treated fairly, with respect and in a non-discriminatory way.

- The trust was not a member of the Royal College of Anaesthetists Anaesthesia Clinical Service Accreditation scheme. This is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.

## Pain relief

- We found that pain relief was managed appropriately. On the wards we found that nurses responded quickly to patient buzzers and requests for pain relief. Patient pain levels were scored using recognised tools and pain levels were checked during ward rounds. The patients we spoke with reported that their pain relief had been managed effectively. Nurses told us that they encourage patients to inform them about their pain, but some male patients recognised they needed to get better at asking for help from nurses.
- We found that pre-operative assessments of surgery patients included adequate assessment for post-operative pain relief. This information was shared proactively with staff on the wards to ensure that patients' pain relief needs were met.
- The hospital had a dedicated acute pain team, which was available during normal working hours only. Nurses told us that the acute pain team was easily accessible via a bleep call system, but that the pain team was not available in evenings or at weekends.
- Nurses used a three stage process for identifying pain relief needs on the wards: mild, moderate and severe. First stage relief included Paracetamol and Ibuprofen. Second stage relief included use of Morphine, and in third stage pain relief for more serious pain cases nurses contacted the acute pain team and used patient controlled analgesia (PCA) pumps. Nursing staff were trained in using syringe drivers and pumps.

## Nutrition and hydration

- Nutritional assessments for pre-operative patients were not made until admission unless the patient was seen by a member of the Proactive Care of Older People (POPS) team during pre-admission. Pre-admission assessment of nutrition needs would provide more time for staff ensure that nutritional needs could be met. Patients' fluids were assessed prior to surgery and fluids were prescribed in line with Royal College of Surgery guidance. Waterlow score risk assessments also included body mass index measurements which were used to inform fluid prescribing.

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- Patients we spoke to on wards gave positive feedback on the quality of food. One patient told us that it was “the best hospital food ever”. However some patients felt that there was limited choice.
- Food orders were requested at around 11:00 and all special diets were catered for by 12:30. A dietician submitted special dietary requests to the kitchen following assessment, such as low fat or high protein meals. There was an online referral process to the dietetics team. Ward managers told us this was a straightforward process and dieticians came up to the ward to complete detailed assessments. Nurses told us that the dedicated nutrition team was available when needed and responded quickly to requests.

## Patient outcomes

- The number of elective surgery day cases at the trust was approximately 55%, lower than the England average of 78%. The trust was investigating ways to increase this. From April-June 2015 5.2% of surgery patients had an unplanned overnight stay. The trust did not submit site specific data on day case rates.
- Day case surgery was analysed on a procedure basis and the trust used the British Association of Day Surgery tool to monitor and record performance information. However, there was no clinical day surgery lead, which meant that there was no routine overview of day surgery. Nurses told us they have to liaise with staff in each specialty to resolve concerns or issues with day cases. Service leaders recognised the need to improve day case procedures and were gradually relaxing criteria for acceptance as day cases, both medically and surgically. They were investigating advanced procedures such as day case simple mastectomy.
- For elective surgery, the risk of readmission was higher than the England average at trust level. For non-elective care, the risk of readmission was lower than the England average at Trust level.
- The hospital participated in national audits. The trust performed well in the National Lung Cancer Audit, above England averages. The trust had mixed performance against indicators in the National Bowel Cancer Audit and Hip Fracture Audit, but was comparable with the England averages. The trust did not submit data against 11 out of 28 relevant questions in the National Emergency Laparotomy Audit 2014.

However, as a predominantly elective site, there was no data available for Guy's Hospital's performance in these audits. PROMS data were collected but return rates were not known.

- In the Patient Reported Outcome Measures, lower proportions of patients who had undergone procedures for groin hernia and varicose vein reported improvements compared to the England averages. The proportions reporting improvement for other procedures were in line with the England averages.

## Competent staff

- There were effective annual appraisals processes in place for staff across disciplines. All of the staff we spoke with had received an appraisal within the past year. Service managers told us that annual appraisals incorporated assessment of staff behaviours and values, and performance development reviews to identify training needs. Completion of mandatory training was required as a component in all staff annual appraisals. Clinicians and nurses reported a comprehensive performance recording process on the trust's Wired system, which recorded and monitored appraisal completion rates. The surgery directorates reported approximately 70% appraisal completion rate at the time of our inspection, against an annual trust target of 95%.
- The surgery service measured comparative outcomes by clinician using the Copeland's Risk Adjusted Barometer clinical indicators tool. A report was published each month with standardised morbidity and mortality rates, and complication rates for each consultant. The data were reviewed monthly with clinical leads and a dashboard of information on each consultant was published.
- Service managers reported access to a limited training budget, which was provided by NHS England. The main training expenditure was on preceptorship training for newly qualified nurses. Staff had access to specialist courses and training across surgical specialties. This included innovative training solutions such as breast tattoo courses, which were then expanded in house. The trust contributed to fees for Masters Degrees, and staff could apply for one year secondments and transfers to other directorates. The surgery service was introducing a core training programme for newly appointed physician associates.

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- Newly qualified nurses reported good orientation and effective planning of the early stages of their training. All newly qualified nurses were required to complete training in intravenous cannulation, phlebotomy, dementia awareness and conflict resolution.
- Theatre staff told us they were encouraged to develop and were provided with good opportunities for training. Access to university courses included top up modules on anaesthetic nursing, theatre nursing, recovery nursing and mentoring. In house courses in leadership and cardiac nursing were available.
- Clinical governance managers told us that the trust provided a number of training options in quality improvement, risk management, clinical audit, and root cause analysis training. Doctors in training also receive teaching in clinical audit as part of their induction.
- Doctors in training told us that they were exposed to good learning opportunities and were able to meet the requirements of their training curriculum outcomes. They reported good levels of supervision and good access to consultants.
- Guy's Hospital was a Nursing and Midwifery Council pilot site for nurse revalidation. Trust records also indicated good engagement with revalidation processes for doctors in 2014/15, with 130 positive recommendations out of 133 revalidated clinicians across the surgical directorates. There were three deferrals.

## Multidisciplinary working

- We found effective internal multidisciplinary team working (MDT) across surgery services, with specialist nurses, physiotherapists, occupational therapists (OT) and other allied health professionals working with doctors and the surgery wards.
- There were full time physiotherapists attached to each surgical ward, and also a 'buddy' to assist with extra work and mobility needs of patients. Specialist orthopaedic physiotherapists were attached to the two trauma and orthopaedic wards. Physiotherapists assessed patients for discharge and rehabilitation and care plans were produced for complex physiotherapy needs. All of the nurses and ward managers we spoke with reported that the structure of physiotherapists and OTs on the wards works well. There was seven day physiotherapy access until 18:00 each day and the

nurses we spoke with told us that the physiotherapists were kept up to date with patient plans and MDT notes. Physiotherapists come to the ward as soon as patient arrives from post-operative recovery.

- OTs worked across surgery wards and their duties included home visits and liaising with community teams and onward referral to specialist services. Ward managers and nurses told us that OTs reviewed all hip and knee patients at pre-assessment which meant that post-operative care plans were shared with nurses before patients arrived for their procedure. Staff we spoke to told us this helped patients to be discharged more quickly.
- We were told by directorate managers and nurses that 30 minute full MDT meetings were held weekly with representation from the Proactive Care of Older People (POPS) team, nurses, physiotherapists and OTs. Additionally, there were daily 15 minute PSAG meetings for nurses, physiotherapists and OTs each day to discuss discharge of patients and specific patient needs or updates while patients have protected meal times.
- The wards also had links with other allied health professionals, including the outpatient parenteral antimicrobial therapy (OPAT) team, which provided specialist training and advice for patients to manage their own antibiotics. The acute pain team visited the wards to review patients.
- The link nurse system for the ward also included tissue viability, information governance, pain, learning difficulty and IPC. However, service managers believed that the sustainability and effectiveness of the link nurse system was highly dependent on maintaining a stable nursing workforce.
- The trust's established Proactive Care of Older People (POPS) team is an award-winning service and was the first of its kind in the UK. It started in 2003 and was viewed by staff as an essential surgical support service. The POPS service looks after patients aged 65 years and above to improve their medical health before and after surgery by assessing them before surgery, following their care while in hospital and supporting consultants and ward staff. The POPS team included specialist geriatricians, nurses, therapists and support staff. Support was tailored to patients' individual needs. Consultants or specialist nurses performed full medical and nursing assessments. Physiotherapist provided advice and exercises to improve mobility before and after surgery. Occupational therapists gave advice on

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aids and strategies to maximise independence and social workers liaised with social services on behalf of patients and provided advice on any support patients may be entitled to. The POPS team covered the whole pathway for each patient and addressed all issues in one place.

- We observed a very comprehensive and effective handover where both surgical and POPS team consultants were present. Each subspecialty doctor in training presented the cases to the consultant of the week and good communication was facilitated by the electronic patient records system. The POPS registrar simultaneously reviewed the patient using the e-notes which included test results, observations and NEWS scores.
- While the POPS service worked well, we were informed that POPS could not take anaesthetic decisions and patients sometimes had to be seen twice, and colocation of services would be advantageous.

## Seven-day services

- The hospital delivered a full service on six days, with on call availability seven day per week. Operating theatres were used on Sundays for priority list patients and any outstanding renal patients. The surgery service delivered elective orthopaedic lists on weekends. Elective plastic surgery cases were delivered every other week. Clinical leaders confirmed that wards were set up with adjusted staffing to accommodate these additional patients.
- Consultants were not resident on weekends. They were available for telephone advice rather than coming into the hospital.
- Theatre nurses told us that pharmacy, supplies, radiology and pathology services were available on Saturdays which enabled six day working. Sunday services were usually run with minimum staffing and on an on-call basis.
- Physiotherapy and occupational therapy support was available until 18:00 each day.
- Consultant-led ward rounds were conducted on weekends.
- Systems were in place to allow patients to be discharged at weekends, including on Sunday.

## Access to information

- There were Information boards for visitors in each of the wards we visited, included information such as visiting times, and protected meal times. In each ward we

visited there were information boards displaying information linked to four CQC domains (Safe, Effective, Caring and Responsive). There were posters on the boards with information on treating people with dignity and respect; and safeguarding against abuse and neglect.

- There was an effective theatre management system in place and theatre bookings were made by specialty booking clerks. They reported easy access to the system and reported no concerns with access to this information.
- Discharge information was communicated to general practitioners in various ways and the trust facilitated a working group with local GPs to improve communication. The trust was phasing out use of fax machines, with planned end date by October 2015. Partner clinical commissioning groups (CCGs) reported that GPs were satisfied with communication from the surgical service and the service was proactive in organising quality improvements in discharge as part of Kings Health Partners.

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

- Mental capacity assessments were conducted at pre-admission stage. During our inspection there was one deprivation of liberty safeguarding order in place in Queen ward which was in place for a patient being given one to one special observation because they had been assessed as a risk of absconding and lacked capacity. The ward manager told us that nurses had worked with social services to implement Deprivation of Liberty Safeguards (DOLS) and that the patient was isolated in a side bay on the ward. The staff on the ward had been informed of potential challenging behaviour. There is a special assessment form and all HCA and nursing staff receive training in conflict resolution.
- Staff in theatres were able to describe how they would address concerns should a patient not be able to consent to treatment. Examples were shared where a patient's procedure had been deferred due to concerns about their ability to consent. Nursing staff established that the patient was dehydrated which affected their communication. Following consultation with clinicians the patient had their procedure later that same day.
- General Managers told us the hospital safeguarding team helped ward staff if they had doubts or concerns about implementing DOLS.



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- Heads of nursing and general managers highlighted a recent road show held within the hospital's surgery wards to promote awareness of mental capacity, safeguarding, DOLS amongst different groups of staff.
- Training completion data highlighted that 78.5% of staff across the surgical directorates had completed mandatory training on mental capacity awareness and best interest application between January and August 2015.
- The trust audited the undertaking and recording of mental capacity tests in accordance with the principles of the Mental Capacity Act 2005. Audit reports from December 2014 to August 2015 reviewed health records of patients known to have dementia, learning disability or lacking capacity to make decisions about their care and treatment either temporarily or permanently. Across this period 78.3% of staff completed the practice of fully documenting the two stage capacity test. The trust introduced dedicated MCA and best interest recording forms in July 2015 to improve visibility of consent taking information in patient records. The form acted as a teaching aid for junior staff and gave structure to the recording of capacity test results. Audit reports highlighted actions to improve training, regular audit and updates in staff newsletters.
- There were processes in place to ensure that consent was delegated appropriately from consultants to doctors in training. The trust's Risk and Quality Committee audited delegation of consent, and its report highlighted appropriate assurance processes were used to ensure that delegates were suitably trained to take consent. Audit records showed that the surgical directorates were performing well in this area, with 99% of cases recorded consent and 98% using the correct forms.
- We found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for surgery was in some cases being taken on the day of the procedure. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. Despite this, the trust's consent audit records from 2014 demonstrated that 97.9% of patients felt that they were given enough time to make a decision about their procedure. We found that some consent was taken by staff in OPD, but was mostly taken in the SAL or DSU on admission immediately prior to surgery. We were told that consent was usually taken by

non-consultant grade clinicians. Both of these approaches are suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.

## Are surgery services caring?

Good



We found a very caring culture within the surgery services at Guy's Hospital. Across wards and in theatres we observed caring and compassionate behaviour from staff. Nurses engaged with patients in a respectful way and ensured their dignity at all times. Surgery wards performed well in the Friends and Family Test. Patients told us that consultants were good at explaining procedures and showed a caring approach. Information about their care was communicated in an appropriate way. Patients felt fully involved in decisions about their care. We were also told about a few examples of above and beyond actions by nurses on wards.

We found, for the most part, a calm and peaceful atmosphere on the wards and there was good dedicated quiet time. All patients were discharged on the wards so patients were cared for by the same staff members of staff all the way through their care pathway. Emotional support and counselling was available for patients and there was dedicated nurse specialist support for different patient groups and those with complex needs.

## Compassionate care

- All of the surgical wards at Guy's Hospital performed well in the Friends and Family Test between March 2014 and February 2015. The test results for surgery demonstrated a response rate of 38%, comparable with the national average of 37.4%. The percentage of patients who would recommend Guy's Hospital to their friends and family ranged from 92-100% across the surgical wards we inspected. Clinical governance managers told us that directorates for surgery did not use other patient experience data beyond the friends and family test.
- All of the patients we spoke with on the wards reported that nurses and healthcare assistants were caring and kind and they felt that staff treated them well. We observed compassionate care during our inspection of surgery wards and theatres. We observed a team of



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physiotherapists carrying out assessments on patients which included an assessment of their walking and checking the height of their bed and risk of falls.

Physiotherapy staff explained what they were doing at every stage showed kindness and were patient with them. Nurses in the surgical admissions lounge and recovery area were observed speaking to patients in a kind and caring way, and patients were made comfortable with pillows and blankets.

- There were hourly fundamental checks on the wards we visited where nurses checked patients' comfort, pain levels, if they needed to use the toilet and if they needed anything else.
- The patients we spoke with felt that their procedures had gone well. One patient told us they had been on the ward for seven days and said that "the staff are brilliant. I've got no complaints. I am going home tomorrow. It's lovely". Another patient told us "everybody's been fine with me. I've been treated very well, it's just very good". Another patient told us they had an operation yesterday. Their pain was being managed by specialist input. "The staff are great, all is as good as it could be under the circumstances". These quotes were representative of most of the patients we met.
- We were told about examples of above and beyond actions by nurses on the surgical wards. One nurse brought in local newspapers for patients to read each day, and provided herbal tea bags for patients to use, purchased using their own money. There was no trolley service within the wards so patients were not able to buy things like newspapers or confectionary. But patients told us that nurses would buy things for them from the hospital shop and bring it back to them. Another nurse had purchased body sprays for female oncology and breast reconstruction patients who were unable to use underarm deodorant. They had also made shoulder bags for these patients to carry their chest drain bags around with them. Patients felt that this gave them more independence to move around, they felt less self-conscious and it helped them to walk around with more dignity.
- We observed dedicated quiet time on wards, where visitors were not allowed. This contributed to a quiet and peaceful atmosphere for part of the day.
- Surgery patients were discharged directly from the wards rather than in a discharge lounge facility. This meant that patients were not moved around

unnecessarily and were treated by the same nurses throughout their time on the wards. Patients got to know the nurses on the wards and this gave them a sense of continuity and stability.

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

- Patients we spoke with on the surgical wards reported that they felt fully involved in decisions about their care. A number of patients reported positive pre-operative experiences because surgeons had explained their planned procedures and after care in a clear and simple way.
- We found some support for families of patients on the wards. Ward nurses told us that as Guy's Hospital was used mostly as for elective surgery, patients and their families had chosen to be treated there and were therefore aware of what was going to happen before they arrived. Nurses provided regular contact with patients' families and a day room facility was available for patients and their families to use which included chairs and a television.
- We spoke with the parent of an adult patient on Sarah ward who told us they felt fully involved in their daughter's care. They also told us that clinicians and ward nurses had provided good quality care, were good at explaining what they were doing, and were responsive to pain relief needs. They told us that clinicians were good at explaining things in clear terms and nurses ensured patients' privacy and dignity. She felt reassured by the approach of the clinicians and nurses treating her daughter.

## Emotional support

- Nurse specialists provided support to patients in addition to ward staff which meant that patients felt better supported at an emotional time. Clinical support nurses were available for breast care, hip and knee care and end of life care.
- General managers and heads of nursing for the surgery directorates reported that female oncology and reconstructive patients have access to specific emotional support and counselling from within the trust's cancer pathway, with dedicated breast clinical nurse specialists for plastic surgery patients. Dedicated support for amputations patients is also provided by the Trust's vascular directorate.

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## Are surgery services responsive?

Good



Surgery services at Guy's Hospital were responsive to patients' needs. We found good planning and systems in place to meet the needs of local and national patients. Theatre usage was managed very effectively, but there were some challenges with referral to treatment waiting times for some surgical procedures due to demand outstripping capacity. The trust was actively working to reduce wait times by employing additional surgeons and introducing further weekend theatre sessions.

Care of patients with complex needs was well met, and there was good support and understanding of patients' specific cultural and language needs.

Access and flow and bed occupancy was well managed with few surgical outliers on medical wards, but we found that some patients were delayed in the recovery lounge during times of high bed demand. Discharge was managed appropriately with good coordination between nurses and allied health professionals.

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

- As a nationally commissioned, tertiary referral surgery service, Guy's Hospital received a high case load of patients from outside its South London catchment area. In some specialties, such as orthopaedics, almost half of all surgery patients were admitted from within the local area, with 47% of referrals from local Clinical Commissioning Groups.
- Directorates delivering surgical activity operated across both the Guy's and St Thomas' campuses and had multiple outreach sites across South London to improve access for local patients. The surgery service had good links to local GP surgeries and district nurses, and these relationships were strengthened by the trust's strong links with, and co-management of local authority 'hospital at home' services, with the London Boroughs of Lambeth and Southwark. These services specifically review local surgery patients able to be cared at home, and the hospital liaises with local authorities to organise post-operative care support in the community.
- Pathways and post-operative rehabilitation services were in place for local patients. This included support

from the POPs team (see section on multi-disciplinary working) and the Guy's Orthopaedic Outreach team (GOOT). The trust also provided a 'Hip and Knee School' each week which supported patients with post-procedure exercise training.

- There was no engagement with lifestyles teams in tertiary, secondary or primary care to help patients with smoking cessation, weight loss or exercise programmes to improve local health outcomes.

### Access and flow

- Access and flow was managed effectively. Admissions were planned well and patient information was shared proactively to ensure patients' needs were effectively planned for. Surgery ward managers received updated theatre lists on a weekly basis for the following two weeks. Lists were revised each week and discussed at a weekly scheduling meetings.
- We attended a surgical bed meeting, which was held daily and attended by ward managers, senior staff nurses, surgical admissions staff nurses and site nurse practitioners. The meeting was used to identify the location of any spare beds and to agree the allocation of patients. Staff at the meeting also discussed which patients should be transferred from inpatient to day case surgery and this was subsequently confirmed with the consultant surgeon.
- We found highly effective management of theatre utilisation, which was recorded on a daily and weekly basis. Theatre utilisation was running at 94.7% for 2015 and seven day theatre usage was being introduced to help improve capacity. A theatre utilisation group reviewed performance across each surgery area.
- Theatre usage was well managed at Guy's Hospital, but the trust's performance against the 18 week referral to treatment target fell below the 90% target in August 2014, though it has been met since October 2014. General surgery, Plastic surgery and Urology all failed to meet the target. Service managers and clinical leaders reported that increased demand had created some challenges for referral to treatment waiting times. This was identified as a particular challenge in plastic surgery because of high demand and subsequent long waiting lists for breast cancer reconstruction surgery. This, along with demand for foot and ankle procedures was driving waiting time performance issues across the surgery directorate. The surgery directorate had identified solutions to address the delays including

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additional theatre sessions, plans to release a theatre for the specific purpose of bringing the list down, and the employment of a new breast plastic surgeon to deliver Saturday lists.

- In the three months preceding our inspection, the proportion of elective patients who underwent a pre-operative assessment was 98.7%. The nurse-led pre-operative assessment clinic determined if a patient is physically fit enough to have surgery and an anaesthetic. Nurses case manage patients and follow through to check results and actions. Patients with more complex medical issues may be seen in an anaesthetic consultant led clinic. If pre-operative assessment appointment exceeds 18 weeks, nurses telephone the patient to reconfirm the appointment date.
- Nurses told us that 40% of patients were admitted to wards before their procedure if they had more complex needs, for example, Type 1 Diabetes, risk of falls, dementia or sleep apnoea. They recognised that some of these admissions were unnecessary and were starting to consider how they could be avoided.
- Staggered admissions were introduced for some cases to save patients from having to wait all day for their procedure. The Orthopaedics team also operated a standby system to get patients in at short notice.
- We found that bed occupancy was well managed with few surgical outliers on medical wards. Wards were staffed according to throughput and acuity. Each ward aimed to keep one bed free in each bay for unexpected admissions from another ward or St Thomas's Hospital, but all beds were filled by the evening.
- Clinical leaders told us that the service was rarely limited by access to beds and had never had to cancel an elective patient due to a lack of beds. Some nurses in the recovery lounge told us that flow could be impacted by limited bed availability, and this was most frequently on Friday evenings. We were told that ward staff were sometimes too busy to collect patients for transfer to the wards and this blocked recovery spaces. This sometimes meant that patients had waited in recovery for 1-2 hours.
- The trust's minimum notice period for cancellations was six weeks. The percentage of patients whose operation was cancelled and were not treated within 28 days was variable compared to the England average. At the time of our inspection, surgery cancellation rates were at 6.2%, down from 7% earlier in 2015. Cancellations were mainly attributed to extended procedures and priority cases requiring urgent surgery.
- The average length of stay for Guy's Hospital for elective surgery patients was 3.6 days, higher than the national average. For non-elective surgery this was 4.6 days, which was close to the national average. Within these statistics, length of stay for hip and joint replacements were comparable to national average. Length of stay for non-elective orthopaedic patients was 16.5 days, significantly higher than the national figure of 8.5 days.
- Clinical leaders explained that the service was working to reduce length of stay and had introduced new enhanced recovery programmes such as Guy's Orthopaedic Outreach Team (GOOT) which had resulted in stays reduced by 1-2 days per patient.
- Care of medical and surgical outlier patients was managed appropriately. There were daily 'sit-rep' meetings where outliers lists were reviewed. The daily outliers list was colour coded for each type of patient for easy reference for site manager. If a ward manager felt they could not manage a particular patient this was reported to the site manager and a more suitable ward would be found. During our inspection, one bay in Queen ward was being prepared for oncology patients as outliers. These were emergency patients from St Thomas's. We were told that matrons from the different specialties liaised to ensure that patients were provided with appropriate care and oncology nursing support was being sourced for the next day's shift. Appropriately skilled nurses and physiotherapists were temporarily allocated to wards where surgical or medical outliers had been placed.
- Discharge arrangements were effective and the matrons, ward managers and nurses on wards reported few problems with flow, crediting good coordination between nurses and physiotherapists to prepare patients to transfer home and free up beds. However, we observed some challenges with discharge arrangements as a result of delays to prescribed medication from the pharmacy. The Matron and ward managers told us that they try to discharge patients before 10:00 and usually by 12:00. However, many of the patients we spoke to reported delays to their discharge with long waiting times for prescribed medication to

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arrive. In some cases this had resulted in delays of up to five hours. Some patients felt that this impacted on the quality of their overall experience in the hospital and felt that this aspect of their treatment could be improved.

## Meeting people's individual needs

- The surgical service proactively considered and responded to specific individual needs, including cultural and religious needs. Pre-assessment also screened for learning disability which was then recorded on the patient information and management system. As a predominantly elective site, most specific needs were identified in advance during pre-admission clinics which established dietary or isolation requirements. Patients' specific needs were also confirmed by nurses during handover.
- We found effective care of patients with complex needs, including provision of one to one care and observation. Performance reports showed that nursing shifts were allocated for one to one special observation of patients at risk of 'confusion and falls'. A 'level of specialising' form was completed for each patient identified as possibly needing one to one care. Patients were also referred to the safeguarding team if they lacked capacity.
- Effective processes were in place to care for patients with dementia. Ward managers told us that scheduling meetings were used to identify any planned admissions of patients with dementia. If a patient with dementia was due for admission, ward staff would contact the relatives or the patient's support network to establish the level of dementia and the patient's choices and specific needs. On admission to the ward dementia screening questions were asked of all patients. If the responses indicated dementia the ward staff made a referral to the POPS service for additional support. There were dementia champions in the hospital that had dementia awareness training and supported other staff on caring for patients with dementia. Specialist nurses from a dedicated dementia team were available, with a link nurse system to ensure the ward was up to date with dementia care and practice.
- Provision was made in the recovery area to allow patients with learning disabilities to see their carers immediately after they had been extubated following surgery.
- Translation services were widely available and utilised. It was estimated that Language Line was used once per week. For a recent live donor transplant involving a non-English speaking husband and wife, two interpreters had been provided for support.
- Multi-lingual information was available for non-English speaking patients. Consent forms and leaflets were provided in a number of different languages, including community languages. Nursing staff had access to a basic translation list, which included pictograms and visual communication aids for deaf patients. 'Multicultural' and pictorial menu sheets were also used.
- Ward managers told us that many African and Mediterranean languages were spoken by ward staff. Local Spanish and Portuguese speaking communities using the surgical service were allocated to a bay with other Spanish and Portuguese speakers and these bays were cared for by a Spanish or Portuguese speaking nurse.
- The wards we visited were used mostly for single sex allocations. When genders were required to be placed on the same wards they were allocated to a single sex bay within the ward to provide a more separate and private space. This included single sex toilet and wash facilities.
- Side rooms were available on surgical wards for patients. We found examples where patients had been moved to side rooms based on need.
- A slips, trips and falls group was attended by nurses from each ward to address patients at risk of falls. Wards monitored their fall rates effectively. Senior ward nurses reported that some male surgical patients were reluctant to use the call bell if they fall because they do not want to 'make a fuss' and they are working with physiotherapists to address this. Patients at risk of falls are signified by a small red square sticker above their bed and it is recorded in e-notes as an alert. They felt that the trust's Falling Star campaign requires more promotion and refresh to ensure it reaches all patients at risk of falling.
- Care of adolescents was considered as 16-17 year old patients were sometimes allocated to adult surgery wards. Care of teenage patients was reviewed on a case by case basis but as a minimum, most adolescents were placed in an individual side bay to make them feel more secure and comfortable. Service managers and senior nurses also told us that dedicated adolescent lists for some surgical procedures were planned in advance so

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that a ward could be allocated entirely for teenage patients. Televisions and computer game consoles were brought in during these periods to make the environment feel less clinical.

## Learning from complaints and concerns

- From June 2014 to June 2015, the trust received 357 complaints (38% of all complaints) regarding the surgery directorates.
- The directorates had designated roles responsible for triaging and coordinating complaints and complaints were reviewed by appropriate clinical staff.
- Ward staff told us that it was rare for patients to complain and that most concerns were managed by a sister at the point when they arise. Service managers and heads of nursing reported some issues with a backlog of complaints and explained that the complaints process had not worked effectively previously because of miscommunication with the trust's central complaints team and limited support and training for staff on drafting responses to complaints. At the time of our inspection the Abdominal Medicine and Surgery directorate had 50 complaints that were open and being reviewed. Staff recognised that more work was needed in learning and sharing the learning from complaints promptly. However, the service was getting through the backlog and the central team had provided training and more support.
- We heard many examples of changes made in response to concerns and complaints. One example was a relative had complained that they had not been kept informed exactly of the whereabouts of their loved one when having an operation and felt anxious they had been in theatres for a substantial amount of time. In response, theatre staff trained ward staff on their computer system so they could see and accurately tell people where the patient was for example "just about to go into theatre" or "in recovery".

## Are surgery services well-led?

Good



Surgical services at Guy's Hospital were well-led. There was a clearly defined vision and strategy and we found effective, visible and accessible leadership by clinicians, nurses and service managers. There was a positive working

environment and culture on wards and in theatres with evident high morale amongst the staff we met. Wards worked efficiently and smoothly. Theatres were well run and staff were well supported, but we were told of some disparity in access to practical learning and development opportunities.

The surgical service were innovating in a number of areas to improve patient outcomes and build capacity within the service, including highly effective multi-disciplinary outreach services. Governance systems were used effectively to monitor and report performance information, but we found that improvements were required to the sharing of information across directorates delivering surgery services.

## Vision and strategy for this service

- There was a clearly defined vision and strategy for surgical services at Guy's Hospital. Consultants, heads of nursing and service managers told us of their vision for a surgical centre that delivered the best outcomes for patients. They recognised the importance of partnership working as a key driver to improving outcomes. Strategic business plans were in place for the whole service. The theatres and wards we visited displayed a poster of their vision at the entrance. Staff had input to these vision statements, which mirrored the overall vision for surgery and the strategic vision of the trust. Nurses on the wards were able to explain the vision and strategy for the service.
- The trust delivers 6,000 major orthopaedic cases per year across both sites and there was recognition by clinical leaders that this may increase to 10,000 per year as district general hospitals reduce their surgical services. Clinical directors explained a desire to consolidate orthopaedic surgery services across South London, with a vision to establish an orthopaedics centre of excellence at Guy's Hospital and to be the best orthopaedic centre globally, adopting a hub and spokes model to take on complex cases at the centre and day surgery, outpatients and lesser orthopaedic work conducted elsewhere within the trust. Clinical directors reported that will mean better outcomes for patients, better training opportunities for staff and more effective procurement. Clinical leaders told us that the trust senior leadership team was supportive of these plans.
- Part of the vision for surgery services was to improve surgical research activity within the trust and clinical leaders recognised that there was scope to increase



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support for clinicians to conduct more research. Some consultants complained to us that the trust was focused on service delivery and unsupportive of clinical research, but managers highlighted that some new junior consultants were being primed to take on research roles. Clinical leaders recognised there was more they could do to support and mobilise staff in this area.

- Guy's Hospital provides all plastic surgery services to south east London and clinical leaders were looking at measures to improve partnership working with outreach clinics across the region by improving and rationalising infrastructure to ensure easier access for consultants and patients.
- Clinical leaders and service managers had discussed their concerns about future reductions to the allocation of surgery training posts and the need for service redesign. Physician associates had been employed to support service delivery.

## Governance, risk management and quality measurement

- Governance, risk management and quality measurement systems were in place across the directorates delivering surgical activity. Clinical and service managers were seen as very supportive of monitoring quality and safety data, and each directorate reported to the trust's performance review meeting. However, we found a number of challenges that were a direct consequence of surgical governance being split across multiple directorates. We found that governance facilitators maintained links together but service managers and heads of nursing reported variations in governance and committee structures which resulted in directorates monitoring, reporting and communicating performance data in different ways.
- Governance structures were similar within each directorate but clinical governance managers told us that a 'one size fits all' approach would not work because of service differences. They explained the different governance structures within each directorate. Each directorate held governance meetings along the following lines: clinical governance meetings held once per month – attended by clinical governance leads (consultant surgeons), pharmacists, matrons and service managers. This covered a governance dashboard which included incidents, risks, complaints, finances, staffing and operational performance. Minutes

of these meetings were shared at monthly specialty boards. Clinical indicators such as falls, medicine errors and pressure ulcers were reported weekly via 'safe in your hands' meetings - a video conference link between St Thomas's and Guy's hospitals which shared 'real time' clinical indicator data from that week. Each unit within a directorate had a weekly 'huddle' meeting with a set agenda. These meetings reported to monthly specialty board meetings. There were also sisters' meetings, a weekly complaints meeting, Surgical Medical Improvement Group meetings, Sit Rep meetings, trust monthly audit meetings and clinical directors' meetings.

- We reviewed a sample of risk registers and minutes from monthly staff meetings and governance meetings across the surgical directorates from April to July 2015. We found evidence of well-structured meeting agendas, comprehensive recording of actions and effective dissemination of information from strategic level meetings to ward level within each directorate. Actions in risk registers were reviewed and updated on a monthly basis.
- It was not clear what formal mechanisms were in place to share information and learning between directorates. Clinical governance managers recognised this was a challenge and that they were looking at ways to share information between directorates more effectively.
- Clinical directors for surgical specialties met weekly with the trust's medical director and other senior executives where surgical concerns and issues were discussed.
- Clinical directors also met with heads of specialty, matrons, general managers and heads of nursing to discuss operational matters such as cancellations and incidents.
- Patient experience information was captured in 'real time' by patient surveys on computer tablets. The survey was also available in paper form. There were structured questions and free text space based on National Patient Experience Survey questions. This allowed the service to pick out the best and worse responses. Where there were examples of good, compassionate practice, we were told this would be used as a constructive and positive feedback for staff, who would be identified for their good work. Where the survey identified poor practice, it was dealt with confidentially and on an individual basis.



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## Leadership of service

- We found good leadership of the surgical service at Guy's Hospital. Clinical directors told us that the trust was very focused on clinical leaders 'leading from the front' and leading by example. Clinical directors attended the trust management executive meeting, which reported to the trust board. Heads of nursing and general managers reported to clinical directors and a team of matrons reported to the heads of nursing. Matrons were very visible and the heads of nursing and general managers told us that matrons were essentially responsible for their clinical areas and for supporting and supervising the work of ward managers and senior sisters. They were also responsible for safety, efficiency and patient experience in their respective areas. Doctors in training and nursing staff told us that there was clear leadership and direction from consultants, service managers and heads of nursing. Senior service leaders were seen as visible and accessible.
- Clinical directors provided examples of where their leadership had brought about changes to service delivery, including the introduction of Saturday operating lists, taking on spinal surgery from other trusts in South London, and building established waiting times into planned service.
- There were effective channels for communication from leadership staff. A monthly MDT board meeting was chaired by the clinical directors and had input from pharmacy and discussed clinical quality. Weekly site meetings took place in the surgery service where ward managers presented data on patient safety, patient experience, quality, specific learning, finance and staffing. Trend analysis of incidents and complaints was also discussed including open cases. Weekly heads of nursing meetings took place, as did bi-monthly matron meetings.
- Staff were encouraged to undertake training to support their leadership development. The trust's 'Fit for the Future' programme was applauded by a number of staff. This required individuals to undertake a leadership project and six days of quality improvement training over a six month period, with support provided by improvement coaches. The trust sponsored staff to undertake Master's degree courses.

## Culture within the service

- We found a constructive culture and positive working environment in the surgery service at Guy's Hospital.

There was evident high morale amongst doctors, nurses and other staff and this was particularly evident on the wards. Many of the nurses we met had worked at Guys and St Thomas' for many years and reported a friendly, enjoyable and supportive ward environment with good work/life balance. Nurses and other health professionals on the wards reported pride in their work and in working for the trust. They felt that the wards were supportive environments and that matrons and managers were visible and available on the wards and open to feedback. Consultants and doctors in training reported a positive working environment and commented that they were 'exceptionally lucky to work here' and that it was a 'privilege to work here'.

- Matrons, ward managers and nurses told us that surgical consultants and doctors in training were very approachable and provided planned opportunities for learning and discussion at monthly audit meetings where they could share learning and concerns and seek support.
- Theatre nurses reported good camaraderie and constructive working relationships between doctors and nursing staff in theatres. However they explained that the busy theatre environment, coupled with many highly skilled clinicians resulted in great demand and pressure on the service. They felt that they had to 'step up' to truly fulfil their roles. They also told us that there was a 'rush rush' culture within theatres to get patients through the system as quickly as possible and that theatre staff were under considerable pressure to perform at pace. 'Super lists' were used previously and this was described as a 'conveyor belt' of patients, with no gaps or rest during a half day list. A super list is where there are two anaesthetists, two anaesthetic assistants and an extra nurse. The purpose is that whilst one patient is on the operating table, the anaesthetist and assistant can be preparing the patient in the anaesthetic room and the extra nurse can assist in taking the patient currently in theatres into recovery. It is designed to increase the flow of patients through theatre. Theatre nurses felt that there was thin margin for error with the rapid pace, but they were confident to ask for breaks and felt empowered to speak up if they had concerns.
- Theatre nurses raised some concerns about the attitude of one individual senior surgical consultant who wanted to work solely with nurses they had worked with previously. They felt that they missed out on some useful development opportunities as a result. They had

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provided feedback on this matter but had not witnessed any shift in the individual's behaviours. The theatre nurses we met also highlighted a recent case where a scrub nurse and circulation nurse were afraid to challenge a known 'difficult character' consultant when a vascular clamp count did not add up and this had led to the investigation of a serious incident, which was on going at the time of our inspection.

## Public engagement

- Clinical governance managers told us that patients are involved in some aspects of governance and development of services. This included involvement in small ways such as reviewing patient information leaflets and documents. The service did not have patient representative groups or members of the public on surgery specific governance committees. Surgery directorates used patient advice and liaison service and patient experience survey data to identify challenges and areas for improvement and were seen as good 'warning mechanisms' by service managers. It was not clear whether there were other fora for learning from patients.

## Staff engagement

- Staff we met reported they felt engaged in decision making about their roles and in wider decision making within their unit. Some clinicians in theatres had attended training on shared decision making, but we found that nursing staff were not familiar with this as a formal concept.

## Innovation, improvement and sustainability

- As a tertiary surgery centre, surgery services at Guy's Hospital experienced a very high throughput of patients. Clinical directors told us that the volume of work was sustainable, but the service had been tasked with saving £2-3 million from an annual budget of £48 million, as part of the trust's wider aim to make £50 million savings. External pressures such as the transfer of surgical cases from other London trusts to Guy's Hospital, and the reduction of surgery training posts, were seen as contributing to capacity challenges. However, we found that Guy's Hospital was investing in a number of innovative practices within surgery to address these challenges, to relieve service pressures and improve patient outcomes.
- The surgery directorate established the Guy's Orthopaedic Outreach Team (GOOT) which managed a

fast track discharge and support service which improved patient outcomes and reduced length of stay. The GOOT team was staffed by a team of nurses, physiotherapists and occupational therapists, who were all multi-skilled across these disciplines. The team provided patients with in-house hip and knee school, home support, and a care information pack including preparing for surgery, recovery and rehabilitation exercises on a DVD. Patients were meeting their markers within one return physiotherapy visit. GOOT won the British Medical Journal prize for best patient literature in 2014 and the trust was seeking to develop a similar service for breast patients next using the same approach.

- The surgery directorate had implemented changes to outpatients appointments to reduce the number of appointments patients were required to attend. The new one stop system was piloted with foot and ankle procedures. Patients attend outpatients clinic, pre-assessment and are given a date for their procedure all on the same day, which meant there was fewer instances of missed appointments.
- The trust's urology unit established a one stop clinic in 2008 which is now well established. The clinic delivers consultation, scope and scans in one day which reduced the need for several appointments. This was identified as a best practice pathway by the London Cancer Alliance Network.
- Extensive use of robotic surgery equipment was evident in Guy's Hospital surgery services, which facilitated more targeted procedures in cancer urology surgery, robotic patellectomy and partial nephrectomy. The trust had purchased a second robotic surgery machine to expand this capability.
- The trust provided a telephone triage pelvic floor continence service for patients. Consultations take place with a senior nurse to discuss symptoms with the intention to get patients to the right part of the service. Waiting times have been greatly reduced and the service has been extended to community referrals. The outcomes of the service were being evaluated.
- The surgery directorate introduced arm bands for patients and staff to identify the nurse in charge on each ward. This innovation was expanded within the trust and has been adopted nationally.
- The trust established a nurse endoscopy initiative to enhance the role of nurse endoscopists in supporting cancer and colorectal pathways. This resulted in enhanced decision making and more rapid action. It has

# Surgery

reduced waiting times by one week. Trust nurses developed a national nurse endoscopy course which was endorsed by the Joint Advisory Group on Gastro Intestinal Endoscopy and nurses from other trusts attend training at Guy's and St Thomas's. A consultant nurse also won the 2014 Nursing Times cancer nurse of the year award for introducing 'straight to test' for colorectal cancer referrals.

- The trust's Hospital at Home service specifically reviews surgery patients who could have care at home and liaises with the London Boroughs of Lambeth and Southwark. The services are managed by the trust in conjunction with the local authorities.

# Critical care

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

## Information about the service

Guy's and St Thomas' NHS Foundation Trust provides the ninth largest critical care service in England and Guy's Critical Care Unit is a 13 bed critical care facility which accommodates level two and level three patients. Management of the unit is the responsibility of a trust-wide critical care leadership team and ward-based staff is shared with St Thomas' critical care service. The unit is located on the first floor of the hospital, adjacent to the surgical theatres and recovery area. Between May 2014 and April 2015, there were 1032 patients admitted to the unit.

Patients are mainly admitted to the unit following elective surgery; however some are also admitted after their condition had deteriorated on the hospital wards. A critical care response team is available to assess deteriorating patients prior to their transfer to the critical care unit and also to follow up patients discharged from the unit.

We visited Guy's Hospital critical care unit for one announced inspection day and one unannounced inspection day. During our inspection we spoke with 16 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team, five patients and three relatives. We checked eight patient records and several pieces of medical equipment.

## Summary of findings

Patients achieved positive outcomes, including good safety thermometer results and a better mortality rate than other similar units. This was due evidence-based care delivered by safe numbers of competent staff. Patients could access the service without delay and there was suitable patient flow through the unit.

There was positive safety reporting culture within critical care and investigations completed as a result highlighted learning points which were clearly communicated to ward staff. Patient records including medicines administration charts were fully completed and medicines were appropriately managed. However, the bed spaces within GCCU were smaller than the recommended size.

Staff were caring and maintained patient privacy and dignity during their admission to the unit. We observed staff treating patients with respect and obtaining consent from patients prior to performing care tasks. Patient and relative feedback about the care they received was positive and there were good facilities for relatives. There were few formal complaints received by the unit and we noted the actions taken in response to informal feedback.

Staff were comfortable approaching the leadership team with any issues and were encouraged to develop professionally. The management team had good

# Critical care

oversight of the unit however, vision for improvements to Guy's Critical Care Unit was minimal and the primary goal for developing critical care within the trust was focused at St Thomas' Hospital.

Staff knowledge of safeguarding principles and Deprivation of Liberty Safeguards was limited and appropriate practice in these areas was not embedded. Staff appraisal rates were low and less than the recommended 50% of nursing staff had a post registration award in critical care nursing. We saw no immediate action in place to ensure sufficient stock of some medicines over weekends which meant some patients missed doses of certain medicines for three weekends in a row.

## Are critical care services safe?

Good



There was a proactive incident reporting culture and staff received feedback from incidents including learning points. Safe numbers of nursing and medical staff were in place on the unit and patient risk assessments were regularly completed. Equipment was readily available and suitably maintained, including daily checks on emergency resuscitation equipment. The bed spaces within GCCU were smaller than the recommended size.

Safety thermometer results were good and there were low rates of unit-acquired methicillin-resistant staphylococcus aureus and Clostridium difficile. Staff used appropriate personal protective equipment and were observed following appropriate hand hygiene protocols.

Patient records including prescription charts were fully completed and we observed medicines were stored and administered appropriately, including controlled drugs. There had been instances where medicines had run out on the unit and there was no response to prevent this from happening again. Staff of knowledge of safeguarding principles was variable and practice in this area was not understood by some staff.

### Incidents

- Incidents were reported via a computer-based form which could be accessed from all computers on the unit. Staff were able to explain how to report incidents and identify the types of scenarios which would trigger an incident report, including near miss situations.
- There were 91 incidents reported on the unit between February and May 2015. There was one serious incidents and no never events reported between September 2014 to August 2015. Incidents reported on Guy's Critical Care Unit (GCCU) were investigated under three headings; medical, nursing and medications. Each incident heading had an allocated clinician to lead the required investigation. We saw evidence of investigation reports, witness statements and root cause analysis (RCA), including action points. Root causes were specified, but it was not always clear how these had been identified as details of how the investigation was conducted were not always included in the paperwork.

# Critical care

We saw evidence patients were informed when issues occurred and apologies were provided. Patients and families affected were also told of learning points identified to prevent the same issue occurring again.

- An online survey was sent to staff in June 2015 to assess the approach of staff towards safety within critical care and a 60% response rate from a range of professions was achieved across critical care within the trust. Results showed a positive approach to safety and suggested staff knew how and when to report incidents. Our inspection supported these findings.
- Feedback and learning points from incidents were communicated to staff via e-mail, text message or on the communication screen in the staff room. Staff told us they received incident feedback frequently and effectively, including action points. We observed feedback being provided during a nursing handover on our unannounced inspection.

## 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, catheters and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety Thermometer and staffing details were displayed at the entrance to GCCU and was entitled "Safe in Our Hands". Safety thermometer data detailed below covered the period September 2014 to August 2015.
- There were no new unit-acquired pressure ulcers reported on GCCU, however equipment related pressure ulcers were not reported under the safety thermometer but were reported as incidents. There were 32 pressure related incidents reported across GCCU and intensive care at St Thomas' Hospital between February and May 2015. However some of these incident forms were submitted for patients who had been admitted with pressure sores rather than having acquired new pressure areas. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow Pressure Ulcer Prevention Score. There was a staff nurse identified as the tissue viability link nurse on the unit.
- Catheter care bundles were used throughout critical care and there had been two instances of CUTIs during the data period specified.

- There were no falls with harm to patients in critical care during the reporting period. We saw evidence of patient mobility assessment by physiotherapists and falls risk assessments completed when patients were considered to be at risk.
- VTE risk assessment was recorded on the electronic patient record and completed on a daily basis. Hospital audit data showed compliance with this assessment was consistently at 100% on GCCU between August 2014 and July 2015. Between September 2014 and August 2015, there were four new VTEs on GCCU.
- Staffing details displayed during the course of our inspection and on our unannounced inspection showed the unit was fully staffed and this accurately reflected the actual number of staff on duty.

## Safeguarding

- The critical care service had access to the hospital safeguarding team on a bleep referral basis. There was a trust-wide safeguarding policy in place which was accessible to all staff via the intranet.
- Compulsory safeguarding training, including mental capacity and Deprivation of Liberty Safeguards (DoLS) principles, had been completed by 97% of staff working between GCCU and critical care at St Thomas' Hospital.
- Staff knowledge relating to safeguarding was variable. Most senior members of staff were able to fully explain what might trigger a safeguarding concern and the steps to be taken in this instance, whereas junior staff were less clear. Junior staff were able to describe some types of safeguarding concerns and told us they would discuss any worries with a colleague but few mentioned the involvement of the safeguarding team.

## Cleanliness, infection control and hygiene

- Two housekeepers worked shifts to provide cover from 7am to 3pm and a further staff member worked from 3pm to 8pm on GCCU. For out-of-hours and 'deep' cleans, a rapid response team was available via a bleep referral system and usually attended within 30 minutes.
- Colour coded cleaning equipment was used to prevent cross contamination between clinical areas. For example, yellow cleaning equipment and personal protective equipment (PPE) was used when cleaning dirty utility areas and blue cleaning equipment and PPE was used for ward areas. We observed this in system use throughout our inspection.
- We observed GCCU was clean throughout, including high level surfaces and the floors. We also found



# Critical care

equipment on the ward including commodes were clean. Cleaning audits were completed by the housekeeping supervisor on a monthly basis and results ranged from 97-99% between April and June 2015. As a result of these audits, actions were identified to address any issues found and we did not see a trend of where improvements to cleaning were needed.

- We saw green 'I am clean' stickers were used on GCCU identifying when equipment had last been cleaned and by whom. Staff told us equipment would be cleaned again after one week even if it hadn't been used, to ensure it was ready for use.
- There was an allocated lead consultant for infection prevention and control (IPC) who was responsible for critical care across both sites. They liaised closely with microbiologists and IPC nursing team to ensure adherence to trust policies and procedures. This consultant was also responsible for monitoring local IPC performance, taking action via equipment provision and training when required.
- In addition to the trust IPC policy, we saw a critical care side room priority guideline was in place on GCCU. This gave a list of conditions where isolation in a side room was essential, strongly advised, recommended if possible or unnecessary. We observed patients being barrier nursed on the main ward area with isolation signs in place in line with trust policy.
- A negative pressure isolation side room was available for patients who required barrier nursing and a positive pressure isolation side room was available for patients who were immunosuppressed. Each of these side rooms had a decontamination lobby which was compliant with infection control requirements.
- We observed most staff wearing PPE such as gloves and gowns during patient contact in accordance with the trust's IPC policy. Different colour aprons were used in adjacent bed spaces to prevent staff moving between areas in the same PPE.
- Disposable curtains were used between bed spaces and all were seen to be labelled with the date they were put up. Staff told us they were changed routinely every three months or sooner if a barrier nursed patient had been cared for within that bed space.
- Staff were observed cleaning their hands with hand sanitizer or washing with soap and water throughout our inspection. We noted alcohol gel was available at

each bed space as well as at strategic points throughout the unit. Hand sanitizer was also available at the relatives waiting area and at the ward entrance; although no hand washing facilities were located here.

- Most staff were seen to be 'bare below the elbows' however we saw two staff members wearing rings with stones or bracelets which were not compliant with this policy.
- Patients were swabbed for methicillin-resistant staphylococcus aureus (MRSA) and gram negative bacteria on admission. Intensive Care National Audit and Research Centre (ICNARC) data showed no concerns relating to unit-acquired MRSA rates and performance in this area was better than in other similar units.
- ICNARC data showed incidence of unit-acquired of *Clostridium difficile* (C. Diff) was generally better than in other similar units, however one set of data demonstrated an anomalous spike in occurrence.
- Unit-acquired blood infections occurred more frequently than in other similar units according to ICNARC data, however this trend was improving. There were nine, intravenous line-related bloodstream infections within the trust critical care service throughout 2014 and 1 between January and June 2015. Minutes from the Intensive Care Infection Control Meeting attributed these infections to the late removal of lines. In response to the rate of blood stream infections, monthly audits of insertion and ongoing care of intravenous lines and central venous catheters were completed on GCCU. Compliance with best practice guidelines fluctuated between 90% and 100% from April to August 2015.

## Environment and equipment

- Care was provided in GCCU in ten bed spaces in an open ward area and three side rooms. There was a central nursing station with medicines storage in an area directly behind this. There was storage for linen and consumables and a dirty utility room located directly on the unit. Entrance to the unit was controlled via a buzzer entry system which meant staff could identify visitors before allowing them entry to the unit.
- The bed spaces within GCCU were smaller than the current recommended size which could place patients at risk of cross contamination.
- There were three isolation rooms available within GCCU; one had facilities for maintaining negative pressure ventilation (suitable for infective patients) and one was

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able to maintain positive pressure ventilation (for the protective of immunosuppressed patients). These two isolation rooms had a decontamination lobby in line with best practice guidance; however the third isolation room had no lobby area.

- There were four hand washing sinks located within the main ward area and hand-sanitizing gel was provided at each bed space. At the entrance to the ward, signs advised visitors to clean their hands with hand-sanitizing gel.
- A full range of basic PPE, including gloves of varying sizes and aprons, were available within each bed space. Additional PPE items for example face masks and visors were available within the consumables storage on the ward.
- There was a clinical waste bin available at each bed space and additional waste bins available throughout the unit, which meant staff did not have to carry dirty items through the unit to dispose of them.
- A dirty utility room was located on one side of the unit and was accessible from the critical care corridor as well as the ward. The room contained facilities for disposing of clinical waste and cleaning equipment. There were hand washing facilities for staff available within this area.
- There were two arterial blood gas analysers available within the technicians' office on GCCU. These machines were noted to be clean and calibrated twice daily; we saw documentary evidence of this with no gaps evident.
- Needle sharp bins were available at each bed space and within the medicines preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- Emergency equipment such as a resuscitation trolley and difficult intubation trolley were available on the unit and the contents of these were checked on a daily basis. Documentation found on the trolleys specified which items needed to be checked on which trolley and demonstrated these checks were happening on a daily basis. On inspection we found one item of equipment which was a week out of date; all other contents were within their expiry dates.
- A storage area for consumables was located on one side of the unit with equipment stored in electronic storage cupboards which required a log in and fingerprint confirmation to access. This system required staff to

input what they removed from the store which meant stock control was managed automatically. Stock was clearly labelled and neatly stored which assisted staff in finding items promptly.

- Medical equipment including ventilators and arterial blood gas analysers were maintained by the in-house equipment technicians. We saw evidence equipment servicing was up to date and items had recently been 'portable appliance safety tested'. Technicians were responsible for sourcing replacement equipment if needed. If new items were ordered, a business case was required to obtain permission for release of funds.
- Items of equipment to assist patients with communication difficulties for example white boards and picture charts were located in a designated trolley found on the unit. Staff told us this was used frequently with patients such as those with tracheostomies.

## Medicines

- From 9am to 5:30pm Monday to Friday, there was a dedicated pharmacist allocated to GCCU. During weekends, an on-call pharmacist was responsible for critical care across the trust, including cross-site at St Thomas's Hospital. There were eight specialist pharmacists providing cover for critical care areas across the trust, which was sufficient to meet recommended pharmacist to patient ratios.
- Electronic prescription charts were used on GCCU. The risk register listed concerns regarding access to up to date patient prescriptions if the computer system failed. To mitigate this risk, staff were required to print out paper versions of patient prescriptions every 24 hours and we saw this occur during our inspection.
- We reviewed several electronic prescription charts on the unit and saw they were fully completed, including details of any missed doses. We saw patient allergies recorded on the computerised system and allergy warning signs were in place above patient bed spaces where appropriate.
- Staff told us medicines were prescribed according to recommendations specified within the British National Formulary (BNF) and trust antibiotic guidelines. We saw doctors on GCCU referring to a BNF dated September 2010, which meant they were in danger that they were not following the most up to date guidance when prescribing.
- Oxygen was prescribed for patients in most instances and we saw evidence of oxygen administered was

# Critical care

reviewed regularly. Most patients received oxygen via a piped supply, but cylinders of oxygen were available at the head of each bed space. All cylinders checked on the unit were seen to be in date and most were correctly stored in racks. However the cylinders within patient bed spaces and some within the storage area were freestanding, which was not an appropriate way to store these.

- Medicines were correctly stored in secured units, which were accessed via a log in name and finger print confirmation. There was a designated area within the medicines storage for patients own medicines.
- We observed nursing staff administering medicines following correct procedures, including controlled drugs being checked by two members of staff and patient identification confirmation.
- Trust policy stated agency nurses should not administer medicines. Due to the volume of medicines given on critical care, agency nurses were asked if they felt competent to give medicines and were able to do so if they were happy to do this. This issue was recorded on the directorate risk register and monitored by senior staff.
- Controlled drugs (CDs) were stored in lockable wall units and the authorised signatory list was immediately available on the ward. Documentation showed the stock of CDs was checked twice per day alongside the CD book. We observed nursing staff administering CDs on the ward and following correct procedure, including completing the required documentation.
- During our unannounced inspection, we observed a handover between senior nursing staff on the unit who identified certain medicines had run out over the previous weekend. Each occasion had been reported as an incident, however the problem had occurred for three weekends in a row and we saw evidence patient medicines were omitted due to unavailability. No alterations to stock levels had been made in response to this issue.
- Medicine incidents were reviewed under the critical care medication incidents review group led by the critical care pharmacy governance lead. We reviewed the report produced by this group in June 2015 which showed 64 medication incidents, with no or low harm between March and May 2015 and identified key themes in incident occurrence. For example, an increased number of incidents relating to continuous vancomycin

infusions were noted and appropriate actions to address this issue were identified. Ward staff were able to describe learning points relating to the vancomycin incidents when asked.

## Records

- Electronic patient records were used on GCCU to document details of patient's admissions including reviews by doctors and the multidisciplinary team. Computers were available at each patient bed space and additional machines were available at the nursing station.
- Daily care records documented measurements of patient observations and various assessments as well as holistic information such as family discussions and details of the patient's mood.
- All electronic patient records we checked were seen to be thoroughly completed, with comprehensive shift summaries completed by nursing staff twice per day and ward round documentation, including current medical problems and plans to address these.
- Staff told us reviews by doctors other than the critical care team were also recorded on the electronic patient record and we saw evidence of surgeon reviews post operatively.
- Medicine prescriptions were also documented on electronic records. When patients were stepped down from critical care, these medicine charts had to be manually copied onto paper charts for use on the wards. This was recorded on the risk register due to the risk of errors occurring in the transcribing process.
- No audit of electronic record systems in critical care had been carried out in 2015. However, there are many controls in the electronic record system that do not allow staff to proceed before essential requirements are completed e.g. no drug can be prescribed before the allergy field is completed.

## Mandatory training

- The trust induction included key aspects of mandatory training for new starters such as information governance and health and safety. Further mandatory training for example, infection prevention and basic life support was completed via e-learning modules and additional classroom based sessions.
- Staff were able to complete mandatory training within working hours, during an allocated training shift or when they did not have a patient allocated to them.

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- Mandatory training was up to date for most staff, including safeguarding training, which included Deprivation of Liberty Safeguards (DoLS) and mental capacity training. This training had been completed by 97% of critical care staff across both sites. However, some topics had poor uptake, such as infection prevention and training in which only 58% of critical care staff were up to date with this training.

## Assessing and responding to patient risk

- The electronic patient records provided options for recording patient conscious levels via the Glasgow Coma Scale (GCS) and agitation of sedated patients via the Richmond Agitation-Sedation Scale (RASS). We noted these assessments were rarely documented on patient records despite staff telling us they used these methods of assessment regularly.
- Staff told us the Confusion Assessment Method for the ITU (CAM-ITU), was used to assess whether patients were delirious while on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. However, none of the records we reviewed during our inspection showed this had been completed. During our unannounced inspection, a patient was identified as being newly confused and displaying behaviour that was challenging, but we noted no CAM-ITU had been completed or identified as a need within the patient notes or during the handover process. The Delirium and Dementia (DaD) team were available to provide support for delirious patients when identified and staff could explain how to contact this team.
- Staff told us there was a real focus in avoiding over sedation of patients and managing delirium with active involvement of the pharmacy team. A clinical guideline for this had been developed but was awaiting approval at the time of our inspection.
- Staff told us allergy alert signs were used above bed spaces to highlight if a patient had any allergies. This was used as a reminder for staff prescribing and administering medicines. We saw these signs in use throughout GCCU.
- For patients on the hospital wards with a National Early Warning Score (NEWS) of seven and above, the critical care response team would be bleeped to review them. This service was available from 8am to 8pm Monday to Friday. Outside of this time and for patients scoring up to six on their NEWS, the site nurse practitioner would

be responsible for assessing the patient. Staff told us the critical care response team reviewed every patient who had been on critical care for three days or more once they had been stepped down to the wards. ICNARC data from April 2014 to March 2015 suggested the actual number of patients reviewed after step down was approximately 58%.

## Nursing staffing

- Nurse staffing levels across GCCU and critical care at St Thomas' Hospital was the responsibility of a designated critical care matron between 8am and 6pm Monday to Friday. Outside of these hours, the shift coordinator on East Wing 2 at St Thomas' Hospital carried the matron's bleep and was responsible for overseeing the nurse staffing levels. Staffing requirements were assessed across critical care within the trust as a whole and took into account patient acuity and staff competence. Staff were redeployed to different units when needed to maintain safe staffing.
- GCCU had a supernumerary shift coordinator on duty at all times who had completed training and specific competencies for this responsibility. Rotas we reviewed showed this was always the case and we observed a supernumerary staff member on each shift during our inspection.
- An acuity tool was used to determine safe staffing levels across critical care. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients a ratio of 1:2. We reviewed patient allocation records and staffing during our inspection which showed GCCU complied with these required staffing levels.
- Nursing staff worked shifts from 7:30am to 8pm and night shifts from 7:30pm to 8am, with handovers at the start of each shift. During handovers, staff were told which patient had been allocated to them and then received a general overview of all patients on the unit. A nursing safety briefing, which covered important information such as which patients were being barrier nursed and information about any recent incidents was

# Critical care

also carried out. The 'Big 4' learning points were identified and staff then completed a comprehensive 'patient specific' bedside handover at the start of their shift.

- Best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units suggests no more than 20% agency staff usage per shift. Nursing staff rotas reviewed during our inspection, showed compliance with this guidance.
- Results from a trust-wide critical care workforce mapping exercise in May 2015, completed in conjunction with the South London Adult Critical Care Network, showed band five critical care vacancies for registered nurses were in line with the rest of the network (0%). There were less band six vacancies (21.7% compared with an average of 23.35%), more band seven vacancies (18.8% compared with 12%) and less band 8a vacancies (0% compared with 4.8%) than in other adult critical care centres.

## Medical staffing

- There were 24 critical care consultants who participated in the rota which covered GCCU and critical care at St Thomas' Hospital. The number of consultants was sufficient to meet the consultant to patient ratio recommended by the Faculty of Intensive Care Medicine Core Standards for Intensive Care.
- A workforce mapping exercise was completed in May 2015 in conjunction with the South London Adult Critical Care Network. The results of this showed critical care consultant vacancies across the trust were in line with other adult critical care units (12.8% compared with 12% in other units).
- Consultants were allocated to cover GCCU for a period of three days (Monday to Wednesday) or four days (Thursday to Sunday). There were some periods on the rota where consultants worked on the unit for seven continuous days. Consultants had no additional responsibilities within the hospital while responsible for GCCU. This type of rota system ensured continuity of care and was in line with best practice guidance.
- Consultants were based on the unit during shifts from 8:30am to 9:30pm. Support during daytime shifts was provided by a registrar grade doctor and a junior doctor. Overnight, patient care was led by an airway trained registrar with support from the consultant on an on-call basis. Consultants were available to attend deteriorating or newly admitted patients overnight with a 30 minute

response time. The night registrar was also responsible for reviewing deteriorating patients on the wards alongside the ward night doctors. This meant there was no doctor immediately available on the unit at times.

- Medical handover meetings took place twice each day, during which staff finishing their shift would handover patient details and any relevant updates to doctors starting work. A critical care safety briefing form was reviewed during every handover and covered important information such as which patients were difficult to intubate and any procedures which were planned for the day.
- Doctors completed a formal ward round twice each day and decided upon a management plan for each patient. This was in line with recommendations by the Faculty of Intensive Care Medicine Core Standards for Intensive Care.

## Major incident awareness and training

- Study days were held twice per year for critical care staff regarding the role of the units in the event of a major incident. None of the ward staff we spoke with had attended one of these study days.
- Staff working within GCCU had been involved in an Ebola patient pathway simulation held at St Thomas' Hospital in October 2014. They told us it had been a valuable learning experience, However they were unsure of the procedure for patients at Guy's Hospital.
- Hospital-wide fire alarm tests occurred on a weekly basis and staff were aware when these took place. They were able to locate the fire evacuation policy for critical care and explained a fire marshal would provide more accurate instructions if a fire occurred.

## Are critical care services effective?

Good



Guy's Critical Care Unit provided an effective service. Patients achieved good outcomes and the mortality rate was better than expected. There were few patients discharged out of hours and delayed discharges were less frequent than in other similar units. Evidence-based care was provided by competent staff who underwent a period of supernumerary practice and completed competencies. However, fewer than the recommended 50% of staff had completed a post registration critical care nursing award.



# Critical care

Staff could readily access necessary information, including investigation results. Staff obtained consent from patients, understood mental capacity principles and used independent advocates when necessary, however knowledge of Deprivation of Liberty Safeguards was variable between staff and practice was not embedded in this area. Care was provided with a multidisciplinary approach, however availability of dieticians, occupational therapists and speech and language therapists was limited.

## Evidence-based care and treatment

- Staff on the unit showed us trust-wide policies and procedures which were located on the hospital intranet. The intensive care intranet was shared with the service at St Thomas's Hospital and critical care specific policies were found here. An allocated member of staff was responsible for ensuring critical care policies on the intranet were up to date and reviewed within the necessary time frame. We checked the review date of 113 policies on the critical care intranet and found 30 were beyond the date of review specified.
- Specific care bundles based upon best practice guidance were used on the unit, including ventilators-associated pneumonia (VAP) care bundles. We observed a recent update to the VAP care bundle to keep practice in line with recent research findings; chlorhexidine gel and mouthwash was removed from the care bundle. Hospital audit data showed extremely variable compliance with VAP care bundles, as just 27.8% of bundles checked were fully completed in April 2015 in comparison with 100% in the previous month.
- GCCU used an intubation checklist which ensured all necessary equipment and the patient were prepared for intubation as well as allocating roles to the medical team. This reflected best practice guidance and we observed this in use during our inspection.

## Pain relief

- Hourly pain assessments were completed as part of the usual patient observations and we observed this documented on patient records. Patients reported levels of pain on a scale of zero to five as well as which activities brought on the pain. Pain assessments for unconscious patients were recorded according to patient responses to care activities, such as facial expression during repositioning.

- Patients told us their pain was well managed and they were given regular analgesia plus extra when needed. One patient told us staff were always "concerned about pain" and brought pain relief quickly when requested.
- Staff told us there was a pain link nurse on the unit, who liaised closely with the cross-site pain team and could be used for advice regarding pain management.
- A trust-wide pain team were available to support patients with pain management issues and could be accessed for advice or review on a bleep system. Staff told us this team was readily accessible and would usually review patients on the same day as referral.
- Postoperative patients often had an epidural or patient controlled analgesia (PCA) device in place to manage their pain control. Staff received specific training to manage this type of pain relief and the pain link nurse or other senior staff could provide additional support if needed.

## Nutrition and hydration

- There were 0.15 whole time equivalent (WTE) dieticians allocated to GCCU, which was not compliant with the British Dietetic Association recommended provision of 0.65-1.3 WTE dieticians for the number of beds covered on the unit.
- Patients were reviewed by the dietician as required from Monday to Friday. Over the weekend, nursing staff would initiate enteral feed if required, by following the policy, which was available on the critical care intranet.
- If it was known parenteral nutrition would be required by a patient post procedure, this would be highlighted to the dietician prior to the operation so there was no delay with commencing nutrition.
- Fluid monitoring was recorded on the electronic patient records. Patients who had restricted fluid intake were highlighted during the nursing handovers and this was monitored by all members of staff involved in the patient's care.
- Some patients were able to eat selected foods from a menu with assistance from staff, which included vegetarian, gluten free and halal options. Before food was given to patients, we observed the temperature was checked to ensure it was adequate and this was documented.



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- Patients who were able to drink on GCCU were offered hot drinks at regular intervals and were provided with jugs of water by their bedside. We saw drinks were left within patient reach and staff assisted the patient if needed.

## Patient outcomes

- The unit contributed data to the 'Intensive Care National Audit and Research Centre' (©ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. The ICNARC data quoted in this report, relates to the period from April 2014 to March 2015.
- ICNARC data showed the critical care unit mortality ranged from 3% to 7% throughout the reporting period and the mortality ratio was 0.90, which were better outcomes than on other similar units. The rate of post critical care hospital deaths was better in comparison with other units.
- The hospital target average length of stay on GCCU was 4.3 days and audit data from August 2014 to July 2015 showed this target was met in nine months out of 12.
- ICNARC statistics showed fewer patients experienced a discharge delay of four hours or more from critical care than in other similar units. The hospital target was set at 56% or less and audit data showed this was consistently achieved by the critical care unit between August 2014 and July 2015.
- Patients discharged 'out of hours' between 10pm and 7am are associated with worse outcomes and ICNARC data demonstrated very few patients were discharged from GCCU out-of-hours than in other similar units. Hospital audit data from August 2014 to July 2015 showed there were consistently less patients transferred out-of-hours than the 7% hospital target.
- ICNARC data showed readmissions to critical care within 48 hours of discharge were generally slightly worse than in other similar units. Hospital audit data between August 2014 and July 2015 demonstrated GCCU readmissions were usually more frequent than the 1.3% target set by the hospital. Data provided by ICNARC showed readmission to critical care after 48 hours occurred more frequently than in other similar units. Staff told us this was due to a low threshold for admitting patients who required more care than was available on the wards but who were not true level two patients.

- There were no non-clinical transfers out of critical care between April 2014 and July 2015, which ICNARC data showed was better than on other similar critical care units.
- ICNARC data demonstrated most patients discharged from GCCU, left hospital with the same or better independence than they were admitted with.
- There were no solid organ or tissue donations from patients who died on critical care during the reporting period. Staff told us many patients on the unit were not suitable organ donors, however a referral to the Specialist Nurse in Organ Donation would be made for all patients having treatment withdrawn.

## Competent staff

### Nursing Staff:

- Nursing staff rotated in teams between GCCU and the intensive care units at St Thomas' Hospital on a staggered eight monthly basis. Staff told us this provided development opportunities for staff, as they were exposed to different types of patients on each different unit.
- New nurses were provided with an information booklet entitled "A Brief Guide to being a Critical Care Nurse", which gave a basic overview of the needs of critical care patients as well as expectations of nurses working in critical care.
- All new starters worked as supernumerary members of staff for a designated period of time, during which they had to have specific competencies signed off by a senior nurse before being able to care for critical care patients independently. Staff showed us evidence of competency completion. We saw the National Competency Framework for Critical Care in place for nurses which had to be signed off before caring for patients with specific needs, such as patients with a tracheostomy.
- Staff working as shift coordinators, were required to complete managerial competencies which were divided into themes such as quality measures and staff development. New shift coordinators had the opportunity to shadow colleagues and work with support from a more experienced coordinator to facilitate their learning.
- There was a dedicated clinical nurse educator who was responsible for overseeing the professional development and learning of nurses working on GCCU, as well as supporting student nurses on placement.

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- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. Across intensive care trained staff within the trust (GCCU and East Wing 1 and 2 at St Thomas' Hospital), 46% of nursing staff had an additional critical care nursing award.
- Nurses received training from various members of the multidisciplinary team. For example, physiotherapists completed teaching about airway clearance techniques and speech and language therapists led tracheostomy sessions. Additionally, trust wide end of life study days were held on a six monthly basis and run collaboratively by critical care and the palliative care team for doctors and nurses.
- Staff appraisals had been completed within the previous 12 months for 47% of staff working across GCCU and intensive care at St Thomas' Hospital.
- New starters began work as a supernumerary member of staff while receiving a local induction and signing off essential competencies. They were allocated a mentor, who was responsible for providing support through the induction process and assisting with teaching and signing off competencies when appropriate.

## Medical Staff:

- New medical staff underwent a comprehensive two day orientation and induction programme, which included trust mandatory training, computer systems training and teaching about severe respiratory failure, amongst other topics. Doctors told us the programme gave them confidence in their role and they knew what was expected of them. We saw evidence of the most recent doctor induction programme.
- Junior doctors could access weekly teaching sessions held at St Thomas's Hospital which covered the basics of critical care, such as circulatory failure and basic mechanical ventilation. There was a separate training session for senior trainees which covered more advanced critical care topics, for example, advanced ventilation and mass casualties. Each session was led by a consultant and a trainee doctor. Staff told us there were some difficulties in accessing training due to the training being held at St Thomas' Hospital.
- Staff told us they received informal bedside teaching on a daily basis and the consultants were always happy to provide ad hoc teaching if needed.

- There was a lead consultant for educational management, which involved the organisation of an educational framework for ST and junior doctors, ensuring doctors received supervision and appraisals, as well as facilitating exam preparation.

## Multidisciplinary working

- Ward staff and doctors had a close relationship with staff working on critical care at St Thomas' Hospital. Communication occurred frequently with regards to staffing levels, learning points and patient needs. We saw evidence of a collaborative approach to critical care across the trust.
- A therapy themed ward round took place every Wednesday and therapists provided updates regarding patient rehabilitation and ongoing goals to the rest of the team.
- Ventilator weaning (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own) programmes were agreed collaboratively by the doctors, nurses and physiotherapy staff. These were implemented by all members of the team and were reviewed on a regular basis as well as modified according to patient progress.
- Staff told us formal patient progress meetings were not held routinely, but would be considered for long term or particularly complex patients.

## Seven-day services

- The physiotherapy service was provided by two therapists who were available from 8:30am to 4:45pm from Monday to Friday. The physiotherapists completed airway clearance and rehabilitation with patients on the unit as required. An emergency on-call respiratory service was available out-of-hours and patients requiring airway clearance support would also be reviewed during the day at weekends. The physiotherapy service met the provision requirements of the Faculty of Intensive Care Medicine Core Standards for Intensive Care.
- The critical care response team was available from 8am to 8pm Monday to Friday to assess and provide support for deteriorating patients on the wards. Outside of these times including all day at weekends, a site nurse practitioner was available to review these patients.
- Electronic referrals were completed to access diagnostic imaging services, which were available from 9am to

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5:30pm. An on-call service was available out-of-hours and over weekends for patients requiring urgent investigations. Staff told us access to diagnostic imaging was easy to organise and efficient with minimal delays.

- Speech and language therapists (SALT) were available from Monday to Friday via an electronic referral. Staff told us nursing staff were able to complete some SALT assessments, such as a blue dye test for patients with tracheostomies.
- Occupational therapists (OT) were available within the hospital, but there were none dedicated for GCCU. Electronic referrals were used to access OT support and patients were prioritised by the OTs, with a typical response time of three working days.

## Access to information

- All patient notes including admission details and holistic information were recorded on electronic patient records. Electronic records could be accessed by staff at bedside computers or any other computer with the relevant software installed via a log in and password.
- Patient investigation results were accessible electronically, including blood tests and imaging reports. These results could be uploaded to the patients' electronic record directly for easy access.
- GCCU had an information folder for staff entitled "How to Help your Patient". This contained information in an A to Z format about support and services available within the hospital as well as external organisations which could provide assistance.
- Patients discharged from GCCU had a printed discharge summary provided for their medical notes.
- Staff could access the trust and critical care intranets from the patient bed side computers which allowed ready access to relevant policies and information.

## Consent, Mental Capacity Act and DoLS

- All levels of staff could describe how they would seek consent, where possible, from patients prior to procedures. Where consent could not be obtained, such as if the patient was unconscious, staff told us care was provided in the patients' best interests, for example repositioning to avoid pressure ulcers. We observed staff seeking consent from patients on GCCU, including explaining the rationale behind the procedure being performed.
- Medical and nursing staff were aware of principles relating to the Mental Capacity Act 2005 such as

presumed capacity until proven otherwise and explained specific assessments were required to establish if a patient did not have capacity. The electronic patient records had a specific section for documenting mental capacity assessments, however none of the records we reviewed, had comments about patient mental capacity documented.

- Staff described examples where patients without capacity and no family had been assigned an independent mental capacity advocate (IMCA) to assist with decisions about their care. Staff described the use of IMCAs as "not uncommon".
- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was variable within GCCU; some staff could explain principles of DoLS thoroughly whereas others were unclear about how it was applicable to critical care. Senior staff were unsurprised ward staff knowledge was variable and told us the application of DoLS within critical care had not been formally recorded in a policy, so it was not explicit what steps should be taken and which paperwork should be used for this.

## Are critical care services caring?

Good



Patients were complimentary about the friendly manner of staff and told us they worked hard to maintain patient comfort. Results of the patient feedback survey were positive and we observed a number of thank you cards from grateful patients and relatives. Maintenance of patient privacy and dignity was a priority for staff and confidentiality was maintained.

Relatives told us staff were respectful and polite, involving them in care tasks where appropriate. Patients and relatives were included in decision making about the patients' care and explanations were provided, along with opportunities to ask questions.

Emotional support was provided to patients and relatives by staff as a matter of course and staff liaised with additional support services were needed. Bereavement cards were sent to relatives of deceased patients and a memorial service was held on an annual basis.

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## Compassionate care

- Family satisfaction surveys were sent out to the relatives of all patients discharged from GCCU and intensive care at St Thomas' Hospital and had achieved a response rate of 59% since the project began in January 2014. The survey raised issues such as managing patients' symptoms, nursing staff, medical staff, facilities and support provided. Responses were converted into a satisfaction percentage score. From January 2014 to August 2015, 22 out of 24 domains scored 85% or above for family satisfaction.
- Patients told us their privacy and dignity was maintained at all times and we observed staff pulling curtains around patient areas before completing care tasks. During ward rounds, staff kept patients covered with a bed sheet as much as possible, only exposing the necessary body parts to be examined.
- We observed staff speaking kindly to patients and chatting with them in a friendly and respectful manner. We noted staff speaking to unconscious patients gently and explaining interventions before doing anything to the patient.
- We observed many 'Thank you' cards and notes on display within the unit including praise for the "exemplary care and compassion" displayed by staff and expressions of gratitude ("We can never thank you enough") from previous patients and their relatives.
- Staff were aware of the need to maintain patient comfort and patients told us staff regularly offered to assist with repositioning including moving pillows to a more supportive position. One patient described how staff "worked tirelessly" to maintain patient comfort.
- Staff maintained patient confidentiality and took care not have discussions about patients within earshot of other visitors.
- Relatives were positive about their interactions with staff and told us they were confident in the care patients received. They told us staff were polite and respectful when speaking to patients and visitors.
- We observed a medical ward round where all members of staff present were introduced to the patient, a brief explanation of the patient's progress was provided and the expected next steps were discussed. The patient was involved in all discussions and the team checked the patient was happy with their recommendations.
- Meetings were held for relatives of patients to discuss progress and concerns from either party. Relatives told us these meetings were helpful in assisting their understanding of what had happened to their loved one and to ask questions.
- We observed relatives participating in care activities with their loved one, such as assisting them to clean their teeth. Relatives told us patients and their visitors were asked if they wanted to complete care tasks together or have assistance from the nursing staff.
- Patient diaries were started for patients ventilated for 72 hours and we saw these in place during our inspection. All members of the MDT as well as the patient's relatives and friends were encouraged to write in the diary.
- We observed staff interacting with patients, including introducing themselves and their role prior to completing care tasks or investigations. Staff encouraged patients to make decisions about their day, for example when they would like to sit in the chair.

## Emotional support

- We observed nursing staff providing emotional support to patients as they completed care tasks, for example reassuring a patient before removing an intravenous line. Patients told us staff asked them how they were feeling and offered opportunities to talk about their worries.
- Emotional support could also be provided by the multi-faith spiritual service within the hospital 24 hours per day and representatives from various faiths such as Christianity, Islam and Buddhism could be accessed.
- Bereavement cards were sent to relatives of all patients who died in critical care. This was led by the end of life team within critical care.
- A memorial service was held for attendance by relatives and staff on an annual basis to remember patients who passed away within critical care across the trust. The memorial service was made up of readings, hymns and prayers as well as an address from a senior critical care consultant. There were approximately 150 attendees to this service in December 2014.

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

- Patients told us they felt involved in decisions about their care. They said medical and nursing staff allowed plenty of opportunities to ask questions and explanations were provided in a patient and clear manner.

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- Staff were aware of external support organisations which were available locally and told us they would signpost patients and relatives to these organisations if they wanted this.

## Are critical care services responsive?

Good



Guy's Critical Care Unit provided a responsive service for patients and worked flexibly with critical care at St Thomas' Hospital to ensure all patients who required admission were catered for. No patients had been discharged out-of-hours or for non-clinical reasons for 12 months and delayed discharges were less common than in other units. Patients had access to a multidisciplinary follow up clinic after discharge.

Patients and their families could access spiritual support from a variety of faiths and translators were available to assist communication on the unit. Information leaflets were available in waiting areas and were provided to patients by staff. Use of PALS was promoted to patients and their families by staff and through posters. Patients and families told us they knew how to make complaints. There was a proactive approach to addressing concerns from patients and relatives and there had been no formal complaints in over 12 months. Waiting facilities for relatives were good and an open visiting policy was in place.

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

- GCCU offered 13 level three critical care beds, including three side rooms. An additional four level two patients could be cared for by GCCU staff in theatres recovery if required. Staff told us it was "very rare" for patients to be cared for in recovery and there were no critical care patients there during our inspection.
- GCCU mainly cared for complex patients who had undergone surgical procedures. Staff told us this meant patient flow through the unit was fairly predictable and patients usually had beds booked in GCCU. We observed a morning bed meeting which was attended by the GCCU matron and theatre staff to discuss any bed bookings for that day and to ensure there were sufficient beds for all patients who needed them. Most patients admitted to GCCU required level three support at some point in their admission.
- There were very few elective procedures cancelled due to a lack of critical care beds and staff told us patients would be appropriately prioritised to be cared for in the recovery 'overspill' area if needed.
- There was a large waiting area for relatives with sufficient seating for 12 people and dedicated toilet facilities. Facilities for making hot drinks and a water cooler were available. Books and magazines were provided alongside information leaflets covering topics such as hand hygiene, organ donation and making complaints.
- A digital information screen was located within the relatives waiting area which showed a rolling set of information, including opening times of cafes within the hospital.
- There was no accommodation for relatives available on site, however relatives could access the accommodation on the St Thomas' Hospital site. Three nights free accommodation was offered for relatives who lived far away. A local private car park had to be used to park conveniently for Guy's Hospital.

## Meeting people's individual needs

- GCCU had open visiting hours which meant families could visit patients at times that suited them. Visiting was limited to two visitors per bed space at any one time, so as to limit disruption to other patients.
- Relatives were asked to complete "tell us about your loved one" questionnaires, which requested information about the patient such as what they preferred to be called, communication needs, mobility details, their interests and personal care details. We saw several patients on GCCU with completed questionnaires within their bed space and staff referred to this during their handover.
- Within GCCU, there was a specific quiet room which staff could use to speak to relatives privately about patients or could be used for bereaved families if required.
- A number of leaflets were available within relative waiting areas and from ward staff, for example information about delirium, MRSA and C.Difficile. Some of these leaflets were available in other languages and different format, such as large print, on request.
- A translation service was available for patients and relatives either via a telephone translator or face to face. Staff on the GCCU were aware of how to make bookings for this and could provide examples where this had been implemented.



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- Psychiatric support could be provided by the hospital psychology team following a computerised referral by a member of the nursing or medical teams. Patients were usually reviewed within 48 hours of referral.
- A multi-faith spiritual service was available within the hospital 24 hours per day and representatives from a variety of religions were accessible for patients and their relatives.
- Patients who were admitted to GCCU for more than seven days or those who were ventilated for more than five days were invited to attend a multidisciplinary follow up clinic which had been started in April 2015.
- Patients with a prolonged or difficult wean from mechanical ventilation could be referred to the Lane Fox Unit which was an internal specialist weaning unit. Staff told us the waiting time to access bed on this unit was variable from a few days to several weeks depending on the types of patients on the unit at the time.

## Access and flow

- Care at GCCU was accessible to anyone who required critical care as a “never say no” approach was used for referrals from within the hospital and external organisations. No formal admission criteria were in place and senior staff told us they had never been able to produce a policy which thoroughly covered all eventualities. The service was able to successfully implement this approach due to the flexible way critical care beds were used cross-site within the trust.
- Patients admitted to GCCU were reviewed by an intensive care consultant as part of the patient admission process. This practice met requirements set out by the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- NHS England statistics demonstrated critical care bed occupancy averaged 90% between April 2014 and March 2015, which was consistently above the national average of 80% occupancy.
- Patients discharged ‘out-of-hours’ between 10pm and 7am were associated with worse outcomes. ICNARC data demonstrated very few patients (Less than 1%) were discharged from GCCU out-of-hours compared to other similar units (7-10%). Hospital audit data from August 2014 to July 2015 showed there was just one month with out-of-hours discharges (Representative of 1.3% of patients that month) and so the unit consistently achieved the less than 7% hospital target for out-of-hours discharges.

- No patients were discharged from GCCU for non-clinical reasons between August 2014 and July 2015, which was a better performance in this area than in other similar units.
- ICNARC statistics showed fewer patients experienced a discharge delay of four hours or more from GCCU than in other similar units. The hospital target was set at 56% or less and audit data showed this was consistently achieved by the critical care unit between August 2014 and July 2015.

## Learning from complaints and concerns

- There had been no formal complaints made about GCCU between August 2014 and July 2015. Staff told us any issues which occurred on the unit were dealt with informally by staff and were escalated to the matron if required.
- Throughout the relative waiting areas, posters and leaflets advertising the role of the Patient Advice and Liaison Service (PALS) were in place and contact details were provided. Relatives told us they knew how to raise any concerns with staff on the unit or with PALS. Patients told us they would feel comfortable raising issues with any of the nurses on GCCU.

## Are critical care services well-led?

Good



Guys Critical Care Unit was fully integrated with critical care on the St Thomas’ site; sharing staff, management and learning. A range of national and international research had been completed on the unit and we saw evidence of many staff contributions to book chapters, national guidelines and research papers.

There were effective governance processes in place and staff were able to provide examples of feedback and learning points. Senior staff were aware of risks associated with the unit; these were recorded on the risk register and reflected our inspection findings.

There was little in place regarding service development plans at GCCU, as these were focused on critical care at the St Thomas’ Hospital site. However, staff at GCCU had been fully engaged in developing the plans for the rebuild there, due to the “one service” approach to critical care across the



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trust. Patients were engaged in service development by sharing their experiences in critical care workshops and changes in practices had been implemented as a result of feedback received.

## Vision and strategy for this service

- GCCU was fully integrated as part of the critical care service provided within the trust. Unit staff were shared across both sites according to service need and rotated across the service for learning opportunities. Senior staff also rotated between the critical care areas and managed teams cross-site. Staff told us this worked extremely well and they viewed GCCU and critical care at St Thomas' Hospital as "one service".
- Analysis of the current and future requirement for critical care beds within the trust was completed in 2014 (based on data from 2013/14). This analysis identified a need for up to 60 additional critical care beds over the following five years, based upon capacity levels, anticipated population growth and anticipated increased activity levels. Senior management told us the trust was committed to building a new unit at St Thomas' Hospital to address the expected shortfall of critical care beds. At the time of our inspection, there were no plans in place for any expansion or redevelopment of the GCCU site.
- Staff described the strategy for GCCU as "carry on with business as usual", with an ongoing focus on quality of care. Staff across GCCU were focused on the developments on the St Thomas' site, which further demonstrated their full integration with the cross-site critical care service.
- Senior staff described an anticipated increase in surgical activity within the hospital, placing additional pressure on GCCU for critical care beds. They told us this may affect their ability to readmit patients from the wards who require extra support from staff. It was suggested that development of a 24 hours per day, seven day service from the critical care response team might help mitigate this issue, but there were no formal plans in place at the time of our inspection.
- Senior staff were conscious of the need to maintain a full complement of permanent staffing to allow continuation of the flexible critical care service across the trust and to keep costs of agency staff down. Senior staff described offering plenty of development opportunities and a clear career progression through the service, as a way to attract and retain staff.

## Governance, risk management and quality measurement

- Clinical governance and risk management meetings were held bimonthly and were attended by a range of senior staff committee members including the critical care clinical lead and the directorate deputy head of nursing. There were also representatives from ward level staff such as a junior doctor representative. We reviewed minutes from the meeting in July 2015 which showed a comprehensive review of new incidents and on-going issues. The critical care governance and risk management committee reported to the trust risk and quality committee.
- There was an allocated lead consultant for governance who was responsible for assuring unit compliance with trust governance protocols and working with the patient safety lead to maintain the risk register. This consultant was also involved in the investigation of critical incidents, compiling complaint responses and responding to safety alerts from national bodies.
- Staff received frequent feedback about incidents and plans were in place to add a new Critical Care Safety Signals Bulletin from October 2015 to provide additional information. The critical care multidisciplinary team also attended bimonthly, half day clinical governance meetings for obtain information and feedback. We reviewed minutes from these meetings which provided evidence of teaching and feedback provided. Senior staff told us of plans to increase the frequency of the bimonthly multidisciplinary clinical governance meeting to monthly from 2016. They told us this would allow a wider group of staff to attend the meeting.
- The critical care medication incidents review group, held open meetings for all critical care nurses, consultants, junior doctors and pharmacists. These meetings aimed to improve the safety culture and facilitate shared learning across critical care.
- An allocated consultant took the lead for patient safety, clinical risk and patient experience. This role involved promoting safety throughout clinical processes, reviewing all clinical incidents, educating staff about concerning incident trends and maintaining the risk register alongside the governance lead.
- We reviewed the most up to date version of the critical care risk register (September 2015) and found the contents largely reflected our inspection findings. Two items on the register had been recorded as a risk since 2007, however there had been many updates regarding

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the management of these risks and plans in place to address them. Senior staff were aware of the risks recorded on the register and who was responsible for maintaining the document.

- There was an allocated lead consultant for quality improvement, audit and data management, whose responsibilities included oversight of ICNARC submissions, monitoring compliance with care bundles, populating the critical care performance scorecard and holding bimonthly quality improvement updates.
- Key incident themes were identified as a “Big 4” by the critical care clinical governance committee and reminders of these issues were communicated frequently to staff over the course of a month during handovers and team meetings. The critical care multidisciplinary team also attended bi-monthly, half day clinical governance meetings to obtain information and feedback.

## Leadership of service

- Clinical leadership was the responsibility of the clinical director, who worked closely with two clinical lead consultants for critical care. The lead consultants assumed responsibility for a number of governance issues in addition to shaping the vision and strategy of the service. Critical care consultants told us the vision for the service had been clearly communicated to them and felt supported by the leadership team during their clinical practice.
- Three matrons shared responsibility for critical care areas within the hospital as well as GCCU and were supported by the directorate Head of Nursing. Matrons were allocated responsibility for specific ward areas and were responsible for all aspect of nursing provision within those areas.
- Staff told us the matrons and the head of nursing were regularly seen on the unit and staff were aware of the leadership structure relating to GCCU. Staff felt they had a good relationship with the management team and told us they were friendly and approachable.
- A supernumerary charge nurse was allocated to each nursing shift to provide leadership and facilitate service delivery on every critical care unit. Staff told us the charge nurses were knowledgeable and “always willing” to offer advice and provide support, particularly if staff were caring for a particularly complex patient.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver a safe and

responsive critical care service. Two-way communication around safety and capacity issues occurred frequently and a good relationship between the teams was evident.

## Culture within the service

- There was a positive and supportive culture within GCCU. Staff provided guidance and assistance to one another during patient care tasks and throughout their shifts.
- New starters were welcomed into the team and quickly made comfortable by the friendly approach of other staff and through a comprehensive induction programme, which included specific training and competencies.
- Transparency was evident within GCCU; staff were open to discussing workplace issues or incidents with one another and sharing learning points. Senior staff provided information to ward staff with an honest approach and were keen to receive staff feedback and opinions.
- Ward staff told us they felt comfortable approaching senior staff with ideas, problems and concerns. They believed their views would be respected and any information provided would be dealt with confidentially.

## Public and staff engagement

- A patient and family experience workshop was held in August 2015 which brought staff, previous patients and their relatives together to discuss how their ICU experience could have been improved. We saw evidence of ideas to improve patient and family experiences on ICU, however there were no formal plans in place, as the workshop was held shortly before our inspection took place.
- Monthly critical care staff forums were held to update staff on new processes and to discuss specific topics. Minutes from these forums showed staff were actively engaged with discussing key issues relating to critical care, for example visiting times and reducing delayed discharges.
- Staff awards were allocated on a trust-wide basis. For example, a ‘Going the Extra Mile’ award for staff who performed beyond the call of duty and a ‘Fit for the Future’ award for particularly proactive and forward-thinking staff. We saw evidence that both these awards had recently been awarded to critical care staff.
- Specific staff achievements, such as completing courses or receiving awards, were acknowledged in the critical

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care monthly newsletter and also during a handover session with the staff member present. Staff told us they felt their achievements were recognised by other staff throughout the department.

## **Innovation, improvement and sustainability**

- Critical care had recently introduced a text messaging service, so key information could be quickly and easily disseminated to staff, such as learning points from an incident. Staff had the option of opting out of this type of contact; however staff we spoke with were positive about this form of communication.
- Senior staff were exploring options of communicating with patient's relatives via text message, in a similar way to their staff messaging system. This would not involve communicating sensitive or confidential information; but useful information such as times that would not be good for visiting.
- Senior staff told us of plans to develop a smart phone application which would contain access to up to date critical care guidelines and best practice recommendations. A business case for this concept was in development at the time of our inspection.
- We saw evidence of many unit contributions to published research papers and abstracts as well as book chapters and national guidance between 2013 and 2015. At the time of our inspection there were a number of on-going research projects in place, for example the BREATHE study (protocolised trial of invasive and noninvasive weaning off ventilation), the PEACE study (prevalence of acute and chronic kidney disease treated by renal replacement therapy) and INFECT study (immune failure in critical therapy).
- Regular research meetings were held to review patient recruitment for on-going projects and to review studies which were set to be introduced to the unit in the future. Minutes from the research meeting in August 2015 showed there were an additional eight studies due to be introduced to the critical care service.
- Senior staff told us the trust had forecast a financial deficit for the current financial year. This was the first time finances had leaned towards a deficit for this trust. Within the directorate, a cost improvement of £2 million had been set. Senior staff told us they anticipated saving £1 million by optimising procurement process as well as streamlining medicine use, such as reviewing the sedation protocol.

# End of life care

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

## Information about the service

Guy's and St Thomas' NHS Trust has a specialist palliative care team (SPCT) within the oncology, haematology and cellular pathology Directorate, which provides services to Guy's and St Thomas' Hospitals, a consultant led outpatient clinic and a community palliative care team. End of life care is seen as a working partnership across multi-disciplinary teams including local voluntary sector hospice providers. Clinical nurse specialists (CNS) support the generalist staff in the delivery of end of life care, as well as training and education of nursing and medical staff. The SPCT is led by the lead palliative care consultant, a deputy chief nurse and includes a pharmacist and social workers. In addition, the bereavement centre staff provided information to the public and the chaplaincy team provided multi-faith support.

The core SPCT offer a Monday to Friday 9 to 5pm service. This was supported by a consultant on call service for the GSTT, Kings and Lewisham services. At the time of the visit the 24/7 on call aspect of the service was temporarily reduced due to staffing shortages and visits were restricted to 9pm and call until 11pm. The consultant on-call service remained unchanged during this period.

During the inspection, we visited a variety of wards at Guy's Hospital, including Esther, Blundell, Aston Keys and Samaritan. We spoke with palliative care medical consultants, registrars and junior ward doctors, clinical nurse specialists, registered nurses, bereavement staff, ward matrons, head and assistant heads of nursing, porters, mortuary staff and the hospital chaplain in order to assess how end of life care was delivered.

We reviewed documents relating to the end of life care provided by the trust and the medical records of six patients receiving end of life care. We observed the care provided by medical and nursing staff on the wards, spoke with six patients receiving end of life care and one family member of a patient receiving end of life care. We reviewed performance information held about the trust. It should be noted that the performance data we analysed related to the trust as a whole and was not broken down for each hospital site.

# End of life care

## Summary of findings

We saw that patients benefited from a multi-disciplinary approach to care. Generalist nurses and medical staff worked alongside the specialist palliative care team (SPCT) to deliver a cohesive plan of care.

The SPCT was effective and provided face to face support seven days per week including 24/7 community visiting. Due to staff shortage at the time of the visit on call was restricted to visits until 9pm and calls taken until 11pm. The Consultant rota remained unchanged during this period.

There was good leadership of the SPCT. Staff felt senior managers were willing to help, offered support and guidance, were often seen on the wards and were very approachable. We found many examples of innovative practice, including the AMBER care bundle and a range of training courses for staff in end of life care such as the Sage and Thyme training model, simulation days and Schwartz rounds. Staff in the bereavement office had sourced funding to provide family members with sympathetically designed clothes bags, so they had a more discreet way of taking home personal belongings of a deceased patient, rather than use a plastic hospital property bag.

The hospital had a long term vision and strategy plan around end of life care. This had been drafted by external advisors and staff commented that it was not achievable in its current form, but it was under review. Staff were clear their focus was on providing individualised care, with quality outcomes and multi-disciplinary input. The SPCT encompassed national guidance into its end of life care protocols and practice such as the NHS guidance – Priorities for the Care of the Dying Person and One Chance to get it Right - developed by the Leadership Alliance for the Care of Dying People (LACDP). It also referenced to the National Institute for Health and Care Excellence (NICE) quality standards for end of life care.

Bereavement support was available from a number of sources – staff in the bereavement office, the social workers attached to the SPCT and the chaplaincy. We visited a number of wards and observed patients being cared for with dignity and respect. Staff facilitated rapid

discharge of patients to their preferred place of death. Medicines were provided in line with guidelines for end of life care. Feedback from patients and relatives, both in person during the inspection and gathered by the hospital in its own bereaved carer survey, was overwhelmingly positive.

The hospital was in the process of moving to an electronic-based records system. We found that during this process, staff needed to use three different software systems as well as paper records, which led to some confusion and uncertainty around where to find key information. This was particularly noticeable with regard to 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. We found there was no consistency in the recording of mental capacity assessments.

From January to December 2014 there had been 971 deaths at the trust.

# End of life care

## Are end of life care services safe?

Good



Staff recognised and responded appropriately to changes in risks to patients receiving end of life care (EOLC). On a daily basis, staff assessed and monitored patients for signs of deteriorating health. Risk assessments were in place and we saw these were person-centred, relevant and staff reviewed them daily. There was a specialist palliative care team which provided support and guidance to the ward nursing staff and medical teams.

Staff told us they felt there was a culture of reporting incidents, and a willingness to learn from errors, so as to reduce the risk of them re-occurring. There was a fixed set of anticipatory medicines. Staff told us this was helpful as it made prescribing easier.

The hospital had a number of different training courses in end of life and palliative care. While end of life training was not mandatory for all staff, a training plan was in place which identified which grades of staff should attend the various courses being offered. Nursing staff in the SPCT were all clinical nurse specialists.

Patient records were largely electronic, although the hospital had not completely dispensed with paper records. This created the possibility of records being misplaced, as staff were not always aware of where to record or find patient data. In particular, we found that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were stored in a number of places and staff could not always find them.

### Incidents

- No never events or serious incidents were reported between May 2014 and April 2015.
- The palliative care team provided data about incidents across both sites between February and May 2015, with summaries of action taken and learning from them. Ten incidents had been reported, two of which identified harm or potential harm to a patient. One related to medication and one to a potential safeguarding concern. We saw that in both cases appropriate action had been taken, or was in the process of being taken.
- We were provided with a separate data sheet outlining end of life incidents at Guys for the period 1 February

2015 – 31 May 2015. This indicated there had been eight hospital based incidents, of which three had resulted in harm, and one was a near miss. All related to medication delays or errors. The data included the action taken and learning as a result.

- The trust maintained a record of incidents related to opioid administration. We reviewed those between February and May 2015. There had been 11 incidents in total at Guys, relating to omitted medicines; a delay in providing medicines to patients and the wrong dose being given. No harm was recorded in five cases, with low harm in the remainder. The data provided indicated the action taken and subsequent changes to help reduce the risk of the incidents happening again.
- We saw that staff reported incidents and they were investigated and learning taken from them. For example, a patient had not been discharged in a timely manner and almost missed reaching their preferred place of death, as the hospice involved did not have a sufficient supply of oxygen. The hospital took steps to rectify this and subsequently an investigation of the incident was carried out and solutions put into place to prevent a recurrence.
- Staff commented that they were encouraged to report incidents and to take learning from them. They felt there was a clear 'without blame' approach within the trust.

### Duty of Candour

- Senior staff we spoke with were familiar with the new regulations relating to the duty of candour. One nurse gave an example where a patient was informed of a drug incident. However, junior staff were not aware of the new regulations and their responsibilities in relation to the duty of candour.

### Medicines

- Doctors carried out all prescribing of medicines. None of the specialist nurses were prescribers, although we were told this was something under consideration and was welcomed by the nurses.
- There was a fixed set of anticipatory medicines on the electronic system. Doctors told us having guidance alongside the fixed set of anticipatory medicines made prescribing the appropriate medicines much easier.
- Medication administration records were completed accurately in the records we reviewed.



# End of life care

## Records

- During the inspection we found that the mix of paper and electronic records introduced a level of risk as information and/or instructions could be mislaid or missed.
- Where applicable, ward staff were expected to complete the end of life notification. This was flagged to the SPCT, so the team could ensure all appropriate care was in place for the patient.
- We reviewed the records of seven patients, both electronic and paper where these were still being used. The records were well maintained, with the exception of DNACPR forms and details of conversations held regarding mental capacity. Some DNACPR were in place and easily found, however in some cases staff could not locate them as they were not sure which system they were stored in. This had been picked up by the SPCT who were in the process of developing guidelines for ward staff to address this issue. Senior managers told us they had recently conducted an audit to review the issue. They had also appointed a lead doctor to review how well the DNACPR forms were being completed in practice
- In the 2014 national care of the dying audit, the trust fell slightly below the national average for having DNACPR confirmation in place (94% compared to 96%), but achieved above the national average for discussing DNACPR with patients who were capable of making a decision (65% compared to the national average of 41%)
- In June 2015 the trust had changed the grade of doctor who could sign a DNACPR form, which meant that only those of ST3 grade or above could sign. We saw that senior nurses were aware of this
- Staff commented positively on the multi-disciplinary input to completing DNACPR forms and a patient's DNACPR status was written on the daily handover sheet, however we saw that there was some confusion amongst staff with regard to the location of completed DNACPR forms. Some were being recorded electronically, although not always in the same software package and some were still in paper format.
- Staff were provided with a proforma which they could use to risk assess and determine if a patient was in need of closer observation. This included scope for a mental capacity assessment.

## Safeguarding

- The staff we spoke with said they were provided with safeguarding information.
- The trust told us safeguarding training was mandatory, however not all staff were aware of this and some told us they had not received specific training. Nevertheless, those we talked with knew the process to follow if they wanted to report any issues.

## Mandatory training

- End of life care training was not mandatory for all staff in the trust, however we reviewed its education and training strategy which outlined a number of different training courses in end of life care. The strategy identified which grades of staff needed to attend which course, and a number of the courses that had already been completed.
- We saw that it was compulsory for all medical, nursing and allied healthcare professional staff to watch an end of life training video in their corporate induction. It was also mandatory for palliative care clinical nurse specialists to undergo the Transformers training. The Care after Death and Sage and Thyme training was recommended to these groups of staff. Consultants and matrons were encourage to complete training in the AMBER care bundle. All other end of life and palliative care training was optional.
- The Sage and Thyme model was part of mandatory training for junior doctors in oncology, who commented that it was excellent (the model is designed to train all grades of staff on how to listen and respond to patients/clients or carers who are distressed or concerned).

## Assessing and responding to patient risk

- Ward staff said they would complete an end of life notification for any patient who was recognised as deteriorating. This would be reviewed by the SPCT who would then decide if they needed to be involved, based on each patient's individual needs.
- Staff used a multi-disciplinary assessment tool. This was reviewed and completed by the SPCT for each referral made to them. We saw the tool in use, and staff commented it facilitated the referral process.
- The trust used the early warning score system (EWS) for monitoring acutely ill patients, to alert staff of a deterioration in the patient's condition.

# End of life care

- Where the progression of a patient's illness was clear, the amount of intervention was reduced to a minimum, with the focus based on ensuring the patient was as comfortable as possible at all times.

## Equipment

- Staff we spoke with were familiar with syringe drivers and how to use them. The SPCT told us that if there was a problem or an incident relating to a syringe driver, they would be part of the team investigating the issue and would use this as an opportunity to provide general staff with further training, to reduce the likelihood of problems recurring.
- We saw there was an adequate amount of correctly maintained equipment to assist with the care of end of life patients, including for example, a sufficient number of syringe drivers. The same (McKinley) drivers were used for inpatients as for those being discharged who required this equipment.
- Staff in the mortuary told us they were provided with appropriate personal protective equipment (PPE). We saw satisfactory supplies of gloves and aprons.

## Nursing staffing

- The SPCT, across both hospital sites and the community team, consisted of 15.2 WTE band 7 nurses and 6.5 WTE band 6 nurses. At the time of this inspection there were five WTE vacancies.
- The vacancies notwithstanding, use of agency or locum staff was low.
- The team was managed by a matron, who in turn was supported by a head of nursing. The team was also supported by two full time palliative care social workers.
- Staff rotated across both hospital sites and the community team to give a breadth of experience.
- One patient commented that there needed to be more general staff during the day, but was positive about the care they provided albeit it was not always as prompt as it could be because there were not enough of them.

## Medical staffing

- The SPCT had 4 WTE equivalent consultant posts. Three consultants were currently in post, one leading at each hospital site and one in the community.
- The consultants were supported by two specialist registrars and two junior doctors.
- The consultants were employed full time, and delivered hospital and community based care and an outpatient clinic.

- Out of hours, a consultant was always on call.

## Major incident awareness and training

- The mortuary and its facilities formed part of the major incident plan. However, staff expressed concerns at the existing capacity pressures, which could impact on their ability to assist should a major incident occur. In particular, staff commented on the fact that the mortuary at Guy's Hospital was smaller and less busy than the one at St Thomas' and was already used for additional storage by St Thomas'.
- We raised this with senior managers who acknowledged capacity could be an issue, but confirmed there was a contingency plan in place which included liaising with local funeral directors.

## Are end of life care services effective?

Good



Outcomes for people who used services were positive, consistent and met expectations. There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. We saw the hospital performed well in the 2014 national care of the dying audit, exceeding the national averages in the majority of key performance indicators.

End of life care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. This information was also used to improve patient's care and treatment.

Information about patient's care and treatment and their outcomes, was routinely collected and monitored. This information was used to improve care.

We noted the hospital had struggled to fill its specialist nurse vacancies but at the time of this inspection had recruited a number of new staff. The staff shortage had had an effect on the 24/7 palliative care service which was now operating at reduced hours for a 3 month period.

We also found staff were inconsistent in how they recorded details of mental capacity assessments.

# End of life care

## Evidence-based care and treatment

- In June 2015 the trust put in place a policy for care in the last days of life, which was based on the NHS guidance – Priorities for the Care of the Dying Person and One Chance to get it Right - developed in 2014 by the Leadership Alliance for the Care of Dying People (LACDP). It also referred to the NICE quality standards for end of life care.
- The trust had produced a flow chart poster for staff which outlined its principles of care for the dying, which the trust had implemented following the withdrawal of the previous national care pathway for the dying.
- If an end of life notification was made through the electronic patient record system, supporting documentation would automatically be printed which highlighted the tasks for the medical and nursing teams relating to the five priorities for care of the dying person.
- The AMBER care bundle, which was designed and developed at this hospital to replace the Liverpool Care Pathway, was in use and we saw staff were familiar with it (The AMBER care bundle is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen).
- Care plans for end of life patients were based on the Five Priorities of Care.

## Pain relief

- We saw staff considered adequate pain relief for end of care patients to be a priority. Where needed generalist staff sought guidance and input from the SPCT.
- Nurses we spoke with were clear about the medicines used for pain relief, had good knowledge of their individual patients and demonstrated clear forward thinking with regards to what might be needed so that delays could be avoided.
- Anticipatory prescribing was in evidence. Doctors and nurses showed us how instructions and flow charts had been set up on the intranet so they had immediate guidance as to what analgesia was appropriate.
- We observed where analgesia had been changed following input from one of the SPCT members.
- Patients told us they had received prompt pain relief and their pain was dealt with effectively.

## Nutrition and hydration

- The trust's end of life care policy directed staff to pay particular attention to the patient's nutritional and fluid requirements. However, the 2014 national care of the dying audit had highlighted that the trust fell below the national average for reviewing the dying patient's nutritional and hydration needs, achieving 37% and 39% respectively, compared to the England averages of 41% and 50%.
- We observed the coloured (red) tray scheme was being used to indicate patients who needed additional help at mealtimes.
- We saw that end of life patients were kept hydrated, orally, intravenously or subcutaneously.

## Patient outcomes

- The SPCT told us not every patient nearing the end of life would be seen by the team, but all those referred would be. We saw that referrals were reviewed within hours, the patient was visited and team members provided support to both patient and ward staff. Approximately 40% of all end of life patients were seen by the specialist team.
- We observed general staff using an early warning system to measure a patient's deterioration. The patient was regularly monitored and provided with appropriate care. If the patient was deemed to be nearing the end of life, the early warning system was discontinued and care was planned in line with the five priorities of care for the dying patient.
- We saw staff take a proactive and reflective approach following a ward round. Led by the consultant, the team reviewed what had been done well and what could have been improved.
- Palliative care staff were able to access and add to the 'coordinate my care' records, a pan-London electronic record which could also be accessed by London Ambulance and the on-call doctor service.
- The trust participated in the 2014 national care of the dying audit. The trust achieved five of the seven organisational key performance indicators and performed better than the national average in seven of the ten clinical key performance indicators. It fell slightly below the national average with regard to prescribing pre-emptive medication (17% compared to 50%) and for some of the key performance indicator regarding

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privacy, dignity and respect. We saw the trust had prioritised the actions it needed to take and had achieved a number of these by the time of this inspection.

- The above mentioned audit indicated the trust achieved above the England average for the number of assessments undertaken in the patient's last 24 hours of life (88% had five or more assessments compared to the England average of 82%).

## Competent staff

- The SPCT rotated between the two main hospital sites and the community, so as to enable staff to become skilled at each location.
- The trust experienced challenges in filling its specialist nurse vacancies. A number of measures were in place to address this including developing the skills of existing staff.
- We saw it had also been difficult to recruit trained anatomical pathology technicians (APTs). The trust had employed two trainees so that they could 'grow their own' specialist staff.
- The trust acknowledged, after conducting a review with portering staff, that additional training should be provided to the porters, who had the responsibility to arrange viewings for relatives outside the regular mortuary hours, as they had to assist often distressed people. The porters we spoke with did not raise any issues. They told us they received training from the mortuary team.
- Most of the general nurses we spoke with demonstrated a good knowledge of planning care for patients nearing the end of life and were clear when to seek input from the specialist palliative care team.
- General nurses told us they were given the opportunity to attend end of life care training and some had received an update on the priorities of care.
- One junior staff member was not familiar with the AMBER care bundle and had not had training specifically in end of life care. More senior staff were able to clearly articulate what the bundle was and how it assisted them to care for an end of life patient.
- The trust had recently recruited a considerable number of junior nurses. It was not clear how training in end of life care would be provided to such a large number of staff.

- Staff told us and records confirmed that they received regular monthly clinical supervision and an annual appraisal. Group supervision was also provided.
- Mortuary staff told us they had previously been involved in the induction of new nurses, but that at present, this opportunity was not available. To compensate, staff were putting together a handbook for staff which would explain the mortuary process.
- Staff training records were detailed and up to date.
- We saw a detailed competency assessment framework was in place which set out the minimum knowledge and skills required for a deputy clinical nurse specialist in palliative care.
- The chaplains undertook mandatory training in a number of areas including safeguarding, child protection, manual handling, equality and diversity, hand hygiene, the Mental Capacity Act and information governance.

## Multidisciplinary working

- The SPCT included social workers and a dedicated pharmacist which provided a multi-disciplinary input into end of life care.
- The 2014 national care of the dying audit indicated the trust achieved above the England average for multi-disciplinary recognition that a patient was dying (73% compared to the England average of 61%).
- Weekly mortality and morbidity meetings were held with representatives from all wards present. We saw minutes of these where current issues were discussed and learning disseminated.
- General nurses told us they could make referrals to the specialist palliative care team. This could be done without a referral from the medical team and nurses felt this aided prompt care for the patients.
- We saw clear lines of communication and joint working between the mortuary staff, staff in the bereavement centre and the end of life care senior nursing staff.
- The mortuary manager told us they felt involved in the decision making processes within the directorate. They attended meetings and also sat on the tissue donation committee.

## Seven-day services

- In June 2015 the trust had had to reduce its out of hours palliative care service due to a shortage of specialist nurses. At the time of this inspection the palliative care team were available for home visits until 9pm, and

# End of life care

telephone consultation until 11pm. Senior managers told us this arrangement was being regularly reviewed and to date there had not been any confirmed adverse patient outcomes..

- The use of the on-call team was reviewed every quarter to establish if the call outs were appropriate or if another provider, such as the out of hour's doctor service, would have been more appropriate.
- The trust was shortly starting a new 'Pal @ home' home service to provide a rapid response to patients who had been discharged.
- The trust provided an on-call consultant for the times the SPCT was not available.

## Access to information

- When patients moved between teams and services, information needed for their on-going care was shared appropriately, in a timely way and in line with relevant protocols.
- We saw palliative care staff had to reference three different software packages, as well as paper records to record, review and update patient information. This was time consuming and created a risk that information may be misplaced, go unrecorded or not be reviewed.

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

- Where discussions had been held with regard to a patient's mental capacity, we found the degree of recording was inconsistent and staff were not always able to locate it.
- Staff were provided with a specific mental capacity assessment tool; use of this varied from ward to ward.
- Ward staff were able to demonstrate an understanding of the mental capacity assessment process and assured us assessments were carried out.

## Are end of life care services caring?

Outstanding



We saw that the SPCT had embedded a positive culture throughout the organisation for end of life care and staff went the 'extra mile' for these patients.

The hospital scored highly in the national care of the dying audit in 2014 for its level of discussion with patients and their families about impending end of life. We saw end of life patients were involved where possible in their care, and they were treated with respect and dignity.

Verbal feedback from people who used the service and those who were close to them was positive about the way staff treated patients and their relatives. Patients felt supported and thought staff were caring.

Patients were treated with kindness during all the interactions we observed. We saw staff sit and talk with patients ensuring they did not feel rushed and were able to raise any concerns or queries they may have. We also saw that family members were treated with kindness. For example, a pack was available for family members who wanted to stay with their relative. It contained toiletries, a snack, something to drink and a car parking permit where appropriate. We saw staff in the bereavement centre had sourced funding so that they could provide relatives with a proper bag to take home a deceased patient's belongings.

Staff in all of the areas we visited, including the mortuary, bereavement office and chaplaincy, demonstrated a commitment to providing a high quality service to their patients. We saw examples of multi-disciplinary working, for example when fast tracking discharges, so that patients could reach their identified preferred place of death.

## Compassionate care

- Patients told us the nurses were 'really good'; 'there was no delay in getting pain relief'; and they felt well supported by the ward team.
- The bereavement office offered questionnaires to relatives or friends of those who had died. An analysis of those returned between July and September 2014 had indicated 81% of respondents felt the care offered was excellent. More specifically 91% felt their dying relative or friend was treated with respect and dignity.
- We saw staff in the bereavement centre had sourced funding so that they could provide relatives with a cloth bag, decorated with an empathetic picture, for them to take home a deceased patient's belongings.
- An annual memorial service was held at the local cathedral for anyone who had been cared for by the SPCT.
- We saw evidence of good individualised care, including symptom control, fast track discharge plans and discussion with relatives.



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

- Patients and relatives told us staff discussed the plan of care with them and made sure they understood it.
- The 2014 national care of the dying audit indicated that the trust scored highly for discussing with both patient and their relatives/friends their recognition that the patient was dying (86% compared to the England average of 75%).
- We reviewed how staff had dealt with an incident with relatives and saw the matron had diffused the situation and put in place two named nurses for the patient and family.
- Staff shared with us an example of listening to a patient's wishes where a decision was taken to treat a young patient's illness, however when that failed, doctors accepted the patient's wishes for no further treatment.
- One nurse told us they were in awe of the end of life care provided. They said the patient journey was positive, they had individualised care plans and where a preferred place of death had been identified, staff strove to make it happen. As an example, they described how staff had arranged for a patient's dog to be brought to the ward.
- We saw the SPCT consultant arrange a teaching session with a therapist for a relative so that they could also provide massage therapy for their family member.
- Mortuary and bereavement office staff demonstrated they understood where religious needs required a prompt burial and worked hard to facilitate this.

## Emotional support

- We observed a ward round led by the SPCT consultant. We saw staff talk with patients in a caring, gentle and informative manner and where possible included relatives and their needs in the discussions. No patient was hurried and they were given as much time as they needed to ask questions or discuss concerns.
- The 2014 national care of the dying audit indicated the trust achieved above the England average for the number of assessments of spiritual needs of the patient and their nominated relatives or friends achieving 60% compared to the England average of 37%
- The chaplain confirmed they would visit wards when requested to support patients and relatives.

## Are end of life care services responsive?

Good



End of life care services were planned and delivered in a way that met the needs of the patients. The services at Guy's reflected the importance placed on patient choice and continuity of care.

A number of booklets were available for patients and their relatives, including one which described the role of the palliative care team.

We saw patients who were being discharged home were given appropriate medicines even if they did not immediately require them, so that there would be no delay if they were needed later.

The hospital had a target of recording the preferred place of death for at least 30% of its patients. It had exceeded this figure in March, April and May 2015.

The hospital had a 24 hour chaplaincy service and emergency contact details for representatives from other faiths.

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

- Plans were in place to shortly commence a registrar service at the hospital so that bereaved families could collect a death certificate and register a death all at the same time and at the same location.
- We saw the SPCT was forward thinking. For example, in order to embed the replacement for the Liverpool Care Pathway, funding had been sourced to engage two facilitators to enhance the implementation of individualised care plans.

## Meeting people's individual needs

- We saw where patients had specific needs, for example a visual impairment, staff had placed a sign by the bed to inform other staff of this. The sign asked that they made themselves known to the patient.
- Patients and relatives could access a chapel or a multi-faith prayer room if they wished. An informative leaflet was available which outlined the role of the spiritual health care team. The same team also provided a bereavement guide.



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- We saw the hospital had a noticeboard giving information on the chaplaincy services available during the day. There was an on-call (Christian) chaplain available out of hours; with emergency contact details available for representatives from other faiths.
- The chaplain told us they had a number of volunteers and they also ran a training programme for people who wished to become hospital chaplains.
- The trust provided booklets with advice for carers when the person they were caring for was approaching the end of their life and guidance on what needed to be done following a death.
- An information sheet was available for patients and relatives, which described the role of the palliative care team and how they could help. This included information, in ten different languages, on how to contact an interpreter if one was required.
- For patients and relatives of patients affected by cancer, the Dimpleby Cancer Care charity provided a drop-in centre at the hospital. This was staffed by health professionals who would signpost patients and carers to information they needed. Books, leaflets, audio- and videotapes and DVDs were also available.
- The bereavement centre carried out the administration of a deceased patient's documents, including the certificate of death.
- Relatives and friends of the deceased could make an appointment to visit the mortuary. If this was out of hours they would be assisted by the porters.
- We saw the mortuary was equipped with copies of the Bible, the Qur'an, the Torah, the Dhammapada and the Bhagavad Gita.
- Mortuary staff told us they were unable to provide facilities for religious washings.
- If a deceased patient had no known next of kin, the hospital would arrange the funeral and mortuary staff would attend where appropriate.
- Where possible, a patient nearing their end of life was given a side room. Relatives were provided with beds and a pack containing basic toiletries, snacks and something to drink. If possible and where relevant, a car parking permit was also provided.
- Entry to the mortuary was controlled via CCTV to prevent inappropriate admission to the area.
- We saw that the refrigerated units in the mortuary were alarmed so that staff would be alerted if the temperature fell outside the norm.
- We found the mortuary provided a satisfactory room for laying out deceased patients and sympathetic surroundings to help with visiting relatives. The walk to the mortuary was poorly signposted and involved walking to the rear of some of the hospital buildings. Staff assured us that no relatives would visit the mortuary unaccompanied. We were unable to verify this as no relatives visited during our observation.
- Staff facilities at the mortuary were poor, however we were informed that a refurbishment had been agreed.
- The hospital had a bereavement centre, which was appropriately furnished. Staff provided relatives with information, but did not provide counselling services.

## Access and flow

- We saw every effort was made to transfer a patient to their preferred place of death, if that had been identified. The palliative care scorecard indicated that in March, April and May, 42%, 37% and 37% respectively of patients who died had a recorded preferred place of death. This was above the target of 30%.
- Once alerted, staff tried to ensure fast track discharges took place within 24-48 hours.
- The palliative care scorecard indicated that between March and May 2015, 89-90% of patients with an end of life care notification were seen face to face within one working day.
- Data provided by the trust indicated that in May 2015, 29% of adult deaths had had an end of life notification. This had fallen from 45% in April and 40% in March, but still exceeded the trust target of 25%.
- The SPCT nurses were able to describe the communication flows and systems that were in place to facilitate the smooth discharge of patients and to ensure the community team were well placed to deliver continuous end of life care.
- The SPCT completed a scorecard each month which covered key performance indicators for the trust. We reviewed the data submitted for March, April and May

## Facilities

- Patients reaching the end of their life were nursed on the main wards. Staff told us that wherever possible they would be nursed in a side room to offer quiet and peaceful surroundings.

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2015. The data showed that 130 referrals had been made to the SPCT in both March and April; and 123 in May. Of these, the team accepted 119, 114 and 106 respectively

- The number of patients with cancer referred in each of the aforementioned months were 63%, 71% and 77%, indicating that the number of non-cancer patients actively supported was in the minority
- Although the electronic system did not automatically flag up if a palliative care or end of life patient had been admitted, ward staff could send an electronic flag to the SPCT to alert them of patients who might require SPCT input.
- The SPCT completed a discharge summary for each patient they saw who was going home, or to a hospice. This was recorded in the electronic notes. Staff were trialling completing a similar summary for every patient they saw, not only those for discharge.
- Patients who were being discharged through the fast track process were given injectable medicines to take home, even if their condition did not immediately demand them.
- The trust provided us with data for the number of patients who had died in their preferred location. In March 2015 this was 65%, April 2015 - 73% and May 2015 - 72%.

## Learning from complaints and concerns

- We saw the palliative care team was proactive in dealing with complaints. For example, it had requested an external investigation in relation to one complaint as it was felt additional scrutiny of the steps the team had taken would be useful.
- The trust provided us with an analysis of complaints for 2014. Of 926 written complaints. Two related to palliative care - one from an inpatient and the other from the outpatient department.
- Staff told us of one complaint from a relative whose request for information was refused because they were not listed as the next of kin. This transpired to be an error in the trust's records, which staff quickly resolved and they ensured the relative received the information they needed.

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

Good



Staff told us they felt empowered to drive forward initiatives and improvements. The local leadership, governance and culture in end of life care at the hospital promoted the delivery of high quality person-centred care.

There was a statement of vision and values for end of life care, which staff were familiar with and were able to discuss with us. A new strategic plan was in the draft stage and being refined so that it had well defined and achievable objectives.

Current objectives were supported by measurable outcomes, which were cascaded throughout the hospital. The challenges to achieving the objectives, including seven day working, were understood and an action plan was in place.

We saw there were a number of governance meetings and working groups tasked to drive forward end of life care developments. The trust had an education and training strategy in place. Some of this strategy was already operational such as the AMBER care bundle. Staff were complimentary about the opportunities to be part of initiatives to improve end of life care.

Staff told us they felt well supported by senior management, in particular the deputy chief nurse, and found them to be helpful, easy to contact and were willing to assist if they were short staffed. They could access a variety of options to feed back, including Schwartz rounds, simulation days and 'chill out' sessions.

Staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They told us they were encouraged to report incidents and/or concerns. There was a clear focus on learning and improvement so that patient outcomes could be enhanced.

We saw that staff took the initiative to ensure guidelines and good practice were shared; and if guidance was not available they would draft it themselves and sent it to senior staff for approval.

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## Vision and strategy for this service

- Staff told us that the hospital's values were important and that staff across all departments were aware of and displayed them. Several members of staff commented that they were proud to work at the hospital.
- An integrated strategy for palliative care and end of life care had been drafted by an external company, with input from staff. It set out the long term vision for end of life care in the trust. Staff told us it would be difficult to put into practice in its entirety, due to cost and complexity, but nevertheless key points within it had been pulled out, prioritised and submitted for approval. Part of this was based on a palliative care workshop held in 2014 which reviewed the strengths, weaknesses, opportunities and threats (SWOT) for the trust. Part of the long term vision for the trust was to be able to offer specific inpatient specialist palliative care beds.
- The chief nurse was the identified lead for end of life care across the trust. We saw that positive end of life care was not only a priority for the SPCT but for the hospital as a whole.

## Governance, risk management and quality measurement

- We saw that the SPCT carried out a number of different roles including regularly reviewing and updating its guidelines, protocols and clinical governance programme. It also provided training for colleagues.
- The End of Life (EOLC) Governance Committee met monthly and had a number of working groups to carry forward EOLC developments. For example, discussions were held about joint teaching between the EOLC team and the learning disability team. These discussions were about the new team of volunteers recruited and trained to sit with isolated dying patients and the outcome of a recent audit on patients discharged with a syringe pump.
- We saw minutes of the monthly meetings of the palliative care clinical governance group. We saw the meeting in April 2015 had reviewed a number of guidelines and made suggestions for improvement.
- Whilst the SPCT had five WTE vacancies, efforts were being made to fill this gap. For example, the managers were assessing if specialist nurses in other fields had the skills to join the SPCT. Actors had been introduced into the assessment process to carry out role-play to enable

the assessors to better determine the assessment skills of the candidates; and nurses were being encouraged to take on roles at a higher grade to gain experience and confidence.

- To help fill the shortfall of SPCT nurses, two GPs had been recruited to offer palliative care services alongside their regular GP provision in the community.
- The suspension of the out of hour's service after 11pm was being continually monitored and there were on-going discussions with commissioners as to viable options, including a possible triage service with a local hospice.
- The lead consultant met regularly with the out of hours GP service to review cases and efficiencies of working.
- The oncology and haematology directorate, where the SPCT sat, maintained a risk register. Up until 14 July 2015, the register contained four amber risks and one red risk specifically concerning palliative care and the mortuary. The red risk related to a shortage of clinical nurse specialists. This had been identified in January 2015. By the time of this inspection, six band 6 nurses, three band 7 and one new matron had been recruited.
- The risk register did not include the potential risk relating to the difficulty staff sometimes had in locating DNACPR forms or confirming they had been completed.

## Leadership of service

- There was good leadership of the SPCT, led by the senior consultant and the chief nurses.
- Staff told us they felt supported by senior management, in particular the deputy chief nurse; found them to be helpful, easy to contact and willing to assist if they were short staffed. Staff were similarly positive about the approachability and guidance offered by the palliative and end of life lead clinician.

## Culture within the service

- We talked with a number of members of the SPCT. They were positive, proactive and able to describe how their work impacted on the overall end of life service.
- Staff were clearly passionate about supporting patients, their family and their friends.
- Staff told us everyone was encouraged to learn from incidents and feedback was always provided.
- Staff felt valued, able to contribute and were enabled to meet and discuss methodology with colleagues from

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different areas than their own. For example, mortuary staff commented they had contact with the clinical nurse specialists and that they were encouraged to contribute to the development of end of life policies.

- We saw a patient-centred approach where the quality of the patient experience was seen as a priority.
- Across the wards we visited, we saw that general nursing staff and the clinical teams welcomed and worked well with the SPCT.
- Weekly handovers were held for each hospital site SPCT and the community team.
- A triage system was in place to ensure any urgent call could be dealt with promptly.
- Weekly reviews were carried out of all end of life notifications to ensure all necessary elements of care had been addressed and also to assess if anything could have been done better
- Care was taken to ensure the safety of the out of hours team if they were visiting patients. A taxi would collect the team member from home and the driver would remain with the nurse at the patient's home (in an unobtrusive place) until they had finished, at which point they would take them back home. There were also facilities for the police to monitor visits and intervene if they felt it was appropriate.

## Public engagement

- The 2014 national care of the dying audit found that the trust did not have board representation for care of the dying. The trust disputed this at the time, and stated that there was a lay member on the board, but accepted that this needed to be clarified. At the time of this inspection however, there was no end of life lay member.
- We saw, for example, that the cancer patient experience had been the topic of discussion at the Council of Governors meeting in April 2015.
- A rolling survey had been introduced in July 2015, which was being given to all bereaved relatives. The results would be reviewed by the patient experience team and reported to the End of Life Committee.

## Staff engagement







- Regular meetings were held to review how the service operated and to highlight any areas for potential improvement. Staff said they were encouraged to play an active part in these.

- The introduction of the Sage and Thyme training model had improved staff's communication skills and was highly spoken of.
- Simulation days were periodically held to provide staff with training in managing difficult situations.
- Schwartz rounds were held and staff found these beneficial (Schwartz rounds are a practical tool that health and care providers can use to improve the culture of their organisation and support staff).
- Wards had a number of different initiatives to support staff. For example, one held chill out sessions where staff were freed up to attend as the matrons covered the ward.
- Counselling for staff could be accessed at any time.
- Staff told us they were encouraged to take on extra roles and temporary 'acting up' positions so they could gain additional experience.

## Innovation, improvement and sustainability

- The trust had an education and training strategy in place to address what it felt were deficiencies in end of life care in acute hospitals. Some of this strategy was already operational such as the AMBER care bundle, the 'one chance to get it right' simulation programme to improve communication skills and the transforming end of life care educational programme. Two initiatives planned were a 'grand round' involving medical, nursing and pharmacy consultants and junior doctors; and an end of life care presentation which would be used to provide a three yearly update for staff.
- The trust was considering a number of options to improve its on-call service including telemedicine and a triage system with a local hospice. The trust was also reviewing the use of advanced care planning, and considering whether to extend it from community use to the acute setting.
- The trust had identified several key areas for development. These included reviewing and improving collaborative working with community-based providers, such as local hospices and improving patient access to their services.

# 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

There were over 746,804 first and follow-up outpatients appointments booked at the hospital in 2014. Clinics that were held in outpatients' areas included dermatology, orthopaedics, urology, diabetes, dentistry, nephrology, haematology and sexual health clinics among others. Urology and dental clinics were among the most attended clinics in 2014/2015, followed by dermatology, orthopaedics, nephrology, anticoagulation clinics, gynaecology, and oncology clinics. There was no outpatient department and individual outpatients clinics were managed by corresponding surgical or medical specialties and numerous divisions within these specialties.

The imaging department occupied a number of areas within the hospital and included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, X-ray areas including oral X-ray.

We visited the general outpatients, oncology, urology, dermatology, nephrology, orthopaedics, diabetes and endocrine, radiology, women outpatient clinics and dental department. We spoke with 39 patients and some of their relatives or carers. In addition, we spoke with 79 members of staff, including managers, doctors, nurses, radiographers and radiologists, administrators, receptionists and members of the health records team. Doctors working in the hospital provided services in other satellite services including Burrell Street Sexual Health Centre.

We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital and we requested additional information from the trust after our inspection.

# Outpatients and diagnostic imaging

## Summary of findings

Outpatients and diagnostic imaging services provided at the hospital were safe, caring and well managed. However, we observed that the services were not always responsive as the hospital did not meet national targets related to cancer treatment and had performed below the England average since April 2013.

We found there were effective systems for monitoring quality of services and risks associated with its delivery. The hospital was able to assess and respond to patients' risk accurately because it collected accurate data, analysed it, and had effective systems for monitoring patients' referrals and cancellations. The trust met the national waiting time targets for non-urgent referrals.

Staff felt empowered, they were able to take initiative to improve the hospital's performance. We observed strong local and senior leadership, managers were aware and able to oversee outpatients' activity at the hospital. Patients' treatment was well planned; good planning allowed preventing delays to treatment and improving patients' experience. Necessary information, including patients' medical records, was easily available. Patients were treated with compassion, dignity and respect; they felt fully involved in decisions about their care and treatment.

## Are outpatient and diagnostic imaging services safe?

Good



There were systems for reporting incidents and rising concerns, outcomes from these were shared with staff and used for shared learning. Records were stored securely. The environment was clean and hygienic and the hospital was staffed adequately in order to run all of the outpatient and diagnostic imaging services. Incidents related to safeguarding were appropriately recorded and actions were taken to address them.

### Incidents

- Staff stated they were encouraged to report incidents and received direct feedback from their line managers. They had access to an online reporting form and told us they were confident using it. Staff were able to give us examples of where practice had changed as a result of incident reporting. We were told all incidents were investigated using a root cause analysis tool, taken into account the contributory factors which may have contributed to the incident. The managers we spoke with confirmed information relating to reported incidents was collated and discussed by the management at quality meetings and minutes we saw confirmed it.
- Staff told us they were confident in raising concerns with their line managers. Themes from incidents were discussed at quality and risk meetings and team meetings.
- One incident was reported for the outpatients and diagnostic imaging services provided by the hospital through the strategic executive information system (STEIS) between September 2014 and August 2015. It related to a delay in treatment experienced by an oncology patient. The incident was adequately investigated and root cause analysis had been completed.
- There was one never event related to delivering outpatient services at the hospital where the wrong tooth was extracted in May 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The trust reported that prior to the extraction, the tooth was correctly identified, the site



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confirmed and the correct equipment was selected for the procedure. We observed that use of World Health Organization (WHO) surgical safety checklist was in use in dental clinics and in cases where dental surgery took place.

- Between March and June 2015 477 incidents relating to various outpatient departments and diagnostic imaging were reported across the trust. It included eight incidents where patients came to moderate harm and 112 were allocated to the low harm category. Most of these incidents were investigated and closed within a one month from the time of reporting. However, 46 of the incidents reported in March, April and May 2015 remained open in July 2015. In 20 cases, no actions had been taken in response, or outcomes of the investigations, were recorded on the trusts incidents reporting system. These included four incidents categorised as low harm.

## Cleanliness, infection control and hygiene

- Staff working in the outpatient areas had a good understanding of their responsibilities in relation to cleaning and infection prevention and control. Clinical areas we visited appeared clean, and we saw staff washing their hands and using hand gel between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited. The equipment was labelled with the green stickers to show that they were clean and ready to use. Personal protective equipment, such as gloves and aprons, was available for staff use in all areas where it was necessary.
- We observed that hand sanitisers, although available in all of the areas, were not always easily accessible and there was no standardised way of positioning them. For example, in some areas they were placed on the reception desk and in others on the wall. They were not routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands there and then. The director of nursing told us the hospital tried to standardise it but had problems with liquid hand sanitisers frequently going missing in patients' waiting areas.

## Environment and equipment

- All equipment was tested and in date to ensure that it was safe to be used.
- Resuscitation equipment was checked daily and the checks were documented. Medication boxes on the resuscitation trolleys were sealed and in date.

- Equipment used in the diagnostic imaging department had been checked regularly and serviced in line with published guidance.

## Medicines

- Medicines were kept in a locked medicines cupboard, and those that require refrigeration were kept in a fridge. Fridge temperatures were checked to ensure medicines were stored at correct temperatures. Most of the medication was within the date, however, in one of the clinics we saw batches of Lidocaine 2% which expired in November 2014. We brought this to the attention of staff and were assured it would be disposed of. In some of the clinics there were insufficient stock control procedures.
- Although all controlled drugs were accounted for and managed adequately in line with published guidance, the regular medicines were not always adequately accounted for. For example there was no medicines stock record held in the dental department. Staff were unable to demonstrate there was a record of all medicines.
- Medicines audits were undertaken yearly by the pharmacist. We saw evidence of an audit report which showed how medicines were being managed at the clinic. Pharmacy staff also visited the department to audit the use of controlled drugs.
- Staff told us they were trained in medicines management and were aware of their responsibility in the safe administration of medicines. All the nurse consultants and clinical nurse specialists that were nurse prescribers prescribed medicines appropriate to their qualifications, competences, and areas of specialty. They had their own caseload and managed their own, nurse led clinics.
- All emergency medication and emergency equipment and resuscitation trolleys were available, and these were checked daily. However, many of the staff we spoke to were not aware which emergency medicines were available to them and how to use it. They told us they would call the internal hospital's emergency number should there be a need to use it.

## Records

- The clinical records kept were a combination of electronic records and paper records. Paper records in

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the outpatient department were stored securely behind the reception desk. Electronic records were available only to authorised people; computers and computer systems used by the hospital were password protected.

- Patients' paper records were stored at St Thomas' Hospital and delivered by courier approximately three times per day. The medical record team aimed to dispatch records a minimum of one day in advance. Nurses and doctors across all clinics told us occasionally patient records were delivered late, or that they were only given a patient's temporary set of notes. Doctors told us there were still able to see patients and that no appointments were cancelled in result as they had access to parallel electronic record system. Nurses and receptionists told us most of the missing notes could be found on the day of the appointment and it did not cause delays to patients' appointments.
- The trust did not audit records availability in clinics. Nurses and doctors told us required information was readily accessible to them. In cases where health records could not be found in time for clinics, a temporary set of health records were created by clerks who collated all relevant information available from the electronic systems. Clerks were responsible for informing the clinicians and, where relevant, raising an incident report.

## Safeguarding

- The hospital had policies for safeguarding children and vulnerable adults. Staff we spoke with were aware of the policies and procedures with regards to safeguarding and they knew how to raise a safeguarding alert. We noted that incidents related to safeguarding were appropriately recorded and actions taken to address them such as referrals to the local safeguarding team.
- Safeguarding level 2 training for children and adults was part of mandatory training for staff. The training completion rate for staff working in outpatient clinics varied between 67% and 100% with the average at 88% in 2014/2015. However, the information provided by the trust indicated that none of the staff working in clinical imaging and medical physics had completed safeguarding training. Staff working in this department were able to describe safeguarding procedures and potential scenarios where safeguards needed implementing.
- The safeguarding adults' team comprised of safeguarding adults leads, clinical nurse specialists for

dementia, delirium and learning disability, safeguarding trainers, dementia trainers and an administrator. The team worked closely with the clinical leads for dementia and delirium and the Mental Capacity Act 2005.

## Mandatory training

- All staff were required to complete mandatory training in health and safety, fire safety, infection prevention and control, information governance, basic life support, and equality, diversity & human rights. Most of the courses were completed every three years. The trust had set a target of 95% for mandatory and statutory training completion. Records indicated that 85% of all staff working in diagnostic imaging and outpatients departments had completed health and safety and fire safety training and 82% other mandatory training.
- Lowest training compliance rates were recorded for risk awareness training (senior managers; 50%), information governance (75%), infection prevention (81%) basic life support (adults; 84%) and medicines management (85%). The hospital had achieved the 95% target in relation to training in equality, diversity and human rights, resilience and business continuity and health and safety.
- There was a low training rate compliance among clinical imaging and medical physics department. Records indicated that none of the medical staff working within that department had completed fire safety training. We also noted low fire safety and health and safety training compliance level (below 75%) among the administrative and clerical staff working across other departments.
- Staff working at the clinical imaging and medical physics department performed worse than the average for the hospital in regard to training completion (82%). Records indicated 0% compliance with manual handling, infection prevention, information governance, and equality, diversity & human rights training.
- Only 63% of nurses working within medical specialties department had completed basic life support training, it was worse than the hospital average of 83% and much worse than required by the target set by the trust (95%).

## Assessing and responding to patient risk

- Various rapid access 'hot clinics' and walk in services were available across medical and surgical specialties, such as sexual and reproductive health service, chest clinic or first seizure clinic. It helped to prevent delays to patients' treatment and minimise risk of deterioration.

# Outpatients and diagnostic imaging

Many services allowed patients to access care rapidly for example at the HIV clinic where ad hoc appointments were available. There was an older person's assessment unit based at the hospital which offered range of services including comprehensive geriatric assessment, physiotherapy and occupational therapy. The clinic had daily capacity to provide preoperative assessments and to offer telephone advice to local GP's. There was a weekly diabetes clinic which provided a walk in service Monday to Friday which included diabetic foot services.

- Rapid access skin assessment clinic offered one day assessment or treatment of a skin lesion to confirm or exclude a diagnosis of skin cancer. This clinic was staffed with dermatologists, dermatologic surgeons, dermatopathologists and clinical nurse specialists. The clinic aimed to diagnose and offer biopsy or minor skin surgery to treat a lesion on the day of the initial appointment. There were other clinics, including one stop breast clinic, which offered rapid assessment and results of imaging tests (i.e. mammogram, ultrasound) on the day of the initial appointment.
- Most outpatients' clinics offered support over the telephone; it was provided by clinical nurse specialists and patient coordinators and allowed staff to respond to patients' urgent queries.
- Cancer services were structured to allow access within the two weeks target. Patients were referred directly through the two week wait office. There was a system used for monitoring patients' referral to treatment times to identify those who had waited for a prolonged period of time, or those who had experienced multiple cancellations of their appointments. It was used effectively and staff were aware of how they performed in relation to waiting times. Diagnostic and imaging services reported on diagnosis within a timely manner to avoid delays with most of reports being produced on the same day.
- There was emergency equipment available to respond in the event of emergency. The equipment was easily accessible and checked daily.
- There were clear standard operating procedures for diagnostic X-ray and nuclear medicine as required by Ionising Radiation (Medical Exposure) Regulations the (IRMER). These addressed patient identification and responsibilities of individual members of staff, and also set training requirements.

## Nursing staffing

- There was a sufficient number of staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required. The average vacancy rate for dental department, medical specialities, therapies, clinical imaging and GRIDA (genetics, rheumatology, infection, dermatology and allergy) was slightly lower (16.9%) than the hospital average (18%). The vacancy rate among nursing staff was 14.8%. There was a high number of vacant posts held among the administrative and clerical staff in therapies (50%), GRIDA (22%) and clinical imaging services (39%). We did not observe this to impact service delivery.
- Nurses and doctors told us the use of agency staff in outpatient clinics was very occasional. The trust reported average rate the hospital of 4% for GRIDA and medical specialities (May 2015).
- The sickness rate for the outpatient departments was 3% which was in line with the hospital average (June 2014 to May 2014) including the dental department, medical specialities, therapies clinical imaging and genetics, rheumatology, infection, dermatology and allergy department. It was 7.5% among administrative and clerical staff working in dental department and 9% among those working within medical specialities. Nursing staff working within the same department also were unavailable to work more frequently (4.5%) than the average member of staff. We did not observe absence of staff to have an impact on the care and treatment of the patients who attended the outpatient clinics and diagnostic imaging department.
- Overall there was a good level of retention of staff within outpatients; we spoke to many members of staff who had worked at the hospital for many years. Staff turnover rate for dental department, medical specialities, and GRIDA was 17% in 2014/2015. This was in line with the hospital average (17.2%). The worse rate was recorded among administrative and clerical staff working at GRIDA and dental services (29%). The staff turnover rate for nurses was 12%, which was better than the hospital average.

## Medical staffing

- Overall, we observed there was a sufficient number of doctors to run all scheduled outpatient clinics. The vacancy rate among medical and dental staff was at 13.8% due to vacant posts held in the medical specialities department. Most of the clinics where

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doctor presence was required were led by hospital consultants, the trust did not use locum consultants in outpatient departments, and locum consultants were only used to cover on the wards.

- The turnover rate among medical and dental staff at 5% was better than the hospital average (17.2%).
- The sickness levels among medical and dental staff across outpatient specialities were below 0.5%, better than the hospital average (3%).

## Major incident awareness

- There were plans drawn up for the hospital in July 2015 to ensure business continuity and that essential services were not disrupted as a consequence of emergencies and when internal incidents were declared. It was informed by national guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity management framework'. There was a site control room located at St Thomas' Hospital and a satellite unit is located in the clinical handover room at Guys Hospital. These were equipped with suitable site plans and equipment to ensure effective communication and gathering up to date information. Procedures were available which informed local managers and staff on how to act in the event of a major incident, or one that could not be dealt with using regular operational protocols.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Multidisciplinary team work was well embedded among all teams. Suitable clinical guidelines were followed for different patient pathways. Staff were competent and knowledgeable and were appraised regularly. Doctors and nurses had access to information which allowed them to support the decision making process. The hospital followed relevant published guidance and participated in national research projects which allowed informing the care and treatment provided.

## Evidence-based care and treatment

- The access policy was up to date (reviewed in August 2014) and informed by the national access targets, as defined in the technical guidance of the national annual operating framework issued by NHS England. It was a

corporate policy developed for all locations managed by the trust. It referred to best practice guides such as one for managing paper referrals and cancer operational policies to ensure referrals were responded to promptly.

- There was a policy on radiation safety which included dose optimisation policy; it was up to date, reviewed in September 2014. It was in line with current regulations such as the Medicines (Administration of Radioactive Substances) Regulations 1978 (MARS78), Equipment used in connection with medical exposure. Guidance Note PM77 from the Health and Safety Executive 2006, Ionising Radiation (Medical Exposure) Regulations and the Environmental Permitting (England and Wales) Regulations 2010 (EPR10). It set risk management strategies and incident reporting procedures. It also highlighted duties and responsibilities of various staff in relation to radiation safety.
- Monthly audit meetings were organised by many of the clinics, including kidney clinics where audit findings were discussed and shared with staff working at the department.
- Doctors in outpatients were able to demonstrate they were complying with best practice guidance. Clinical staff demonstrated a working knowledge of National Institute of Health and Care Excellence (NICE) guidance for recognising and responding to patients' needs. Clinical staff working within the dermatology department explained the use of NICE guidelines and other national guidelines and gave examples of its implementation. They also gave examples how they influenced changes in the national guidance, informed by the practice and research carried out at the hospital.
- The trust audited implementation of NICE guidelines for colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas, the management of chronic obstructive pulmonary disease (COPD) and management of type 2 diabetes. The trust participated in the national COPD audit programme in 2014, commissioned by the Health Quality Improvement Partnership (HQIP) as part of the national clinical audit programme. Lead clinicians were also required to complete the NICE quality standards self-assessment form in order to identify shortcomings and ensure compliance.
- The sexual health clinic was involved in a national research project in conjunction with Kings College and Birmingham University on the use of gentamycin for the treatment of gonorrhoea (GToG). The study was being



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conducted for a period of 24 months. The clinical staff assessed each patient who accessed the sexual health clinic to establish whether they would benefit from being part of the GToG trial and enrol them into the trial with their agreement and consent.

## Pain relief

- Results of the national cancer patient experience survey 2014 suggested that 79% of cancer patients felt staff did everything to help control pain at all times (day patients / outpatients). These results were in line with the national average. Seventy five per-cent of patients thought staff did everything to control side effects of radiotherapy and 77% answered the same question in relation to side effects of chemotherapy. This was worse than the national average and the trust was positioned in the lowest performing 20% of all trusts.
- The general gynaecology outpatients clinic provided consultation and management for women experiencing general gynaecological problems such as heavy or painful periods, fibroids and pelvic pain and an advanced endometriosis clinic.
- Patients had access to the pain management and neuromodulation centre which supported them in chronic pain management. Other pain management support was offered through INPUT pain management department located at St Thomas' Hospital. This clinic specialised in spinal cord stimulation and management of psychological, physical and social impacts of chronic pain. There was also a headache and facial pain service which provided outpatient care for patients with complex headache disorders. It had a multidisciplinary team which included consultants, clinical psychologists, a neurosurgeon, clinical nurse specialists, research fellows and research nurses.

## Patient outcomes

- The follow-up to new appointments rate for the hospital varied between 3.1 and 2.7 in 2014. This was above the England average (2.3). We were unable to analyse how these corresponded to individual specialties due to a lack of data. Doctors told us this was linked to the nature of clinics organised at the hospital which specialised in long term medical condition management such as diabetes or HIV.
- The trust performed worse than the London average (61%) for the quality of cancer staging data collected in 2012/13 (the process of identifying the severity and treatability of a patient's cancer) when the trust only

recorded data fully for only 47% of cancer patients. We were told that the trust had made progress compared with previous years (comparable data was not published) and in 2014 63% of all cases were fully staged with additional 12% partially staged. The upper gastrointestinal (upper GI) department had seen a near 20% improvement on the number of staged cases. The trust had also recorded improvements within gynaecology (98% fully staged tumours), head and neck (79%), and lung (85%) specialities.

- Patients care was well organised with individual patients being discussed during multidisciplinary team meetings. Bowel cancer audit results for 2014 suggested in all cases the surgery was pre- planned with no need for emergency surgery to take place.
- Lung cancer audit results (2014) showed that a higher number of patients (95%) than average (91%) received a CT before bronchoscopy.
- Results of the national cancer patient experience survey 2014 were mostly in line with the national average and the trust had slightly improved results when compared with the previous year. The survey indicated that 79% of patients thought they were seen as soon as necessary. The trust was among the 20% worst performing trusts in relation to this question. We also noted that 92% of patients were given the name of the clinical nurse specialist in charge of their care. The trust was among 20% of top performing trusts in relation to providing patients with this information.

## Competent staff

- In general, nurses, healthcare assistants, doctors and staff working in the diagnostic imaging department were competent and knowledgeable when spoken to. All the staff we spoke with were able to explain what their role was and told us they were provided with adequate training, development and supervision to ensure they were able to do their job effectively. Clinical and non-clinical staff told us they were provided with annual appraisals of their performance and their appraisal is linked in with their professional development. A member of staff in one clinic told us she was provided with an opportunity to undertake professional study at the university.
- At the sexual health clinic, staff teaching sessions were organised every Wednesday morning. Staff told us they found this training very useful. We saw a rota of the training program for the whole year.



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- The hospital participated in a pilot site for the new revalidation program run by The Nursing and Midwifery Council; the nursing management team at the Burrell Street Sexual Health Centre were part of the program team for the nursing revalidation pilot program.
- Nurses, radiographers and healthcare assistants told us, the trust supported training and that the training offered was effective. Many told us they felt there were numerous career progression opportunities available to them which helped them to achieve high level of motivation and job satisfaction. It was also confirmed by findings of the NHS staff survey 2014.
- Records provided by the trust showed that 66% of all staff working within clinical imaging, medical specialties, dental services and GRIDA (genetics, rheumatology, infection, dermatology and allergy department) were appraised in 2014/2015. It included 79% of nurses and 90% of medical and dental staff. The lowest appraisal rate was noted among nursing staff (60%) and allied health professionals (43%) working in the dental department. Staff told us they were happy with the quality of appraisals.

## Multidisciplinary working

- We noted that multidisciplinary team work was well embedded among all teams with well attended MDT meetings run by all specialties weekly. MDT meetings were attended by the full range of professionals and information and action points from these meetings were circulated to all staff in the department.
- The advance kidney team run an outreach clinic in Tunbridge Wells fortnightly; this was a multidisciplinary (MDT) clinic run in conjunction with other specialists including clinical nurse specialists. The renal department had a good local engagement program with the Kidney Association, they organised local community programs, funfairs' and other public awareness programs.
- Senior managers told us specialist nurses, supported by doctors and other allied healthcare professionals, ran nurse-led clinics for ear, nose and throat and breast surgery, diabetes and endocrine and urology department among many others. We noted other clinics utilised skills of healthcare assistants and clinical nurse specialist by delegating tasks and supporting them with skill development. For example a healthcare assistant working at the orthopaedic clinic was supported to apply simple plaster casts.

- Bowel cancer audit results for 2014 suggested that all patients were discussed at multidisciplinary team meetings and in all cases the surgery was pre-planned with no need for surgery to take place as a result of an emergency. Lung cancer audit results for 2014 also suggested that all patients were discussed at multidisciplinary team meetings and that higher number of patients (95%) than average (91%) received a CT before bronchoscopy.

## Seven-day services

- Most of the outpatient clinics ran from Monday to Friday. They were scheduled to run from 8am to 5pm. Occasional evening and Saturday morning clinics had been organised in the main outpatients to minimise waiting times.
- The x-ray and other clinical imaging services were available Monday to Friday, 9am - 5pm. Others, such as CT scan, provided services for inpatient department and were available seven days a week 8am to 6pm.
- Burrell Street Sexual Health Centre was the first NHS sexual health clinic in London to open seven days a week. Many of the service managers and senior nurses working within outpatient departments spoke about plans to develop six day services. Staff told us these plans were made in response to patients' feedback and were supported by staff.

## Access to information

- Doctors told us they were able to find all relevant information in the electronic patient management system and they were not required to cancel any appointments as a result of lack of availability of information. Electronic patient records were available in hospital clinics, and community clinics. We were told by the clinical staff that no procedures were performed in clinics such as dental or ophthalmology without appropriate medical notes been available.
- Appointment letters were sent to patients on the day of appointment booking or the next working day for all services with an average 2.2 days response time. The trust did not monitor how long it took to report on diagnosis or outcome of the treatment to the patient's local GP. Nurses and doctors told us communication with GPs was effective and that letters were sent promptly. They aimed to send letters within a maximum of five days, there were no backlogs or delays. Allocated patient's coordinators were able to communicate GPs when required.

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

- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with confirmed they had completed their mandatory training and had undertaken regular updates. Records indicated that all staff working in the cardiology outpatient department had completed MCA and DoLS training. The same training was completed by 79% of transplant and renal specialities staff, 71% of staff working in urology clinics and only by 25% of those working in orthopaedic outpatients department.
- Nurses and some of the doctors we spoke with were unclear of the procedures they would follow should a patient's capacity to consent be in question. It included staff working in a specialist dental clinic, where patients with potentially limited capacity to consent were seen. None of the staff had mentioned a need for a mental capacity assessment to take place or clearly described procedures used for reaching 'best interest' decision prior to treatment being offered or the procedure being performed.

## Are outpatient and diagnostic imaging services caring?

Good



Patients were treated with compassion, dignity and respect. Many we spoke to told us they were offered a kind and caring service. Outpatients and diagnostic imaging services were very caring. Patients told us they were involved in decisions about their care and treatment, and were mostly given information in an understandable way. There was various emotional support routinely available to patients.

## Compassionate care

- We witnessed patients being treated with dignity and respect by all staff. Reception staff directed patients to other waiting areas when required and informed of the waiting time. They also advised patients on how to find a way around the hospital if they needed blood tests,

X-rays or other diagnostic services. We observed various staff routinely stopped and offered help when they noticed a patient wondering around hospital looking lost.

- Patient consultations took place in private rooms to ensure privacy and confidentiality of consultation and treatment.
- The hospital started using the NHS Friends and Family Test in October 2014 as required by NHS England. This is a single question survey asking patients whether they would recommend the department to their friends and family. As indicated by responses gathered from April to July 2015 the trust performed in line with the England average with 92% of patients saying they would recommend the service to their friends and family. Records indicated that therapies were among those mostly recommended with between 95% and 98% positive responses received in July 2015. Slight lower scores were reported for clinical imaging and women's services (89%) and medical specialities and GRIDA services (90%).
- Chaperones were provided whenever needed. Staff told us no specific chaperone training had been given to them. There was a chaperone policy which took into consideration management of chaperoning in sexual health and gynaecology. It was guided by national guidance produced by professional bodies such as the General Medical Council and the Nursing and Midwifery Council. The trust had no specific mandatory training around this policy. We were told its content was covered through local induction for the outpatient nursing teams as a core part of their role. The healthcare assistants were required to complete 'fundamentals of care' training where aspects of privacy and dignity were covered including chaperoning a patient in an outpatient clinic.
- In the 2014 national cancer patient experience survey 2014 80% of patients who participated reported that doctors talked in front of them as if they were not there. The trust was among 20% of the lowest performing trusts in relation to this measure. The survey also indicated that 78% of patient felt they were told sensitively they had cancer, 89% thought clinical nurse specialists definitely listened carefully the last time they spoke to them and 88% received understandable

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answers to important questions all/most of the time from them. The trust scored among the lowest 20% of all trusts taking part in the survey for these three measures.

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

- Patients told us they felt they were mostly involved in their care. They said, if they had any queries regarding appointments, they would contact individual clinics or medical secretaries.
- Results of the national cancer patient experience survey 2014 suggested that 70% of patients felt involved in decisions about their care and treatment, and 84% were given written information regarding potential side effects of their treatment, it was in line with the national average. 88% reported that staff gave a complete explanation of what would be done prior to surgery and 74% were given written information. The survey also indicated that in 76% of cases doctors had explained test results in an understandable way, and in 88% of cases provided patients with written information about tests. These results were in line with the national average.

## Emotional support

- In 2014 the national cancer patient experience survey 86% of patients said the hospital staff gave information about support groups. This was better than the national average. Answers to questions related to the hospital providing information about the impact cancer could have on work, education, financial help and free prescriptions were in line with the average.
- Dimbleby Cancer Care is the cancer support service located at the hospital. It was a drop-in information centre, and also offer complementary therapies, psychological support and benefits advice. Patients were also provided with information on where to obtain additional support related to housing and money issues.
- Many of the clinics run regular educational workshops for patients who were affected by long term medical conditions and their family members. It provided patients and their families with opportunities to meet others affected by the same condition and with opportunities to ask questions and voice concerns.

## Are outpatient and diagnostic imaging services responsive?

Requires improvement



Outpatient and diagnostic imaging services were not always responsive as the trust was persistently failing to meet the national waiting time targets related to cancer treatment. However, we also noted that targets related to non-urgent referrals were consistently met. Initial referrals were managed effectively by individual clinics. The trust undertook various initiatives to improve patients experience across the hospital. Complaints were handled in line with the trust policy, they were analysed and shared among the teams to facilitate learning and service improvement.

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

- Some of the patient reported they were occasionally not sure which hospital they were required to attend. We observed at the time of the inspection that a few had arrived at Guy's Hospital when their appointment was scheduled at St Thomas' Hospital. The trust had received three complaints related to this issue in 2015. The hospital had identified that in addition to patient's error the reason for the confusion was the address of the some clinics (located on St Thomas Street) and trusts logo at the letter heading. In response appointment letters were changed to avoid confusion, we saw an example appointment letters. This was part of the trust's 'way finding strategy'.
- The trust's 'way finding strategy' was updated in April 2015. As a part of this initiative the trust had implemented a way finding app named 'my visit' which aided way finding to and throughout the hospital sites. They had developed their signage as guided by the dementia care guidelines and introduced a way finding and access manager who had responsibility for the implementation of this strategy. The strategy focused on simplification and zoning, pre-visit information, and staff and volunteers training. The trust website had a page for feedback from patients and visitors on the environment and how people found their way around the hospitals.

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## Access and flow

- The hospital undertook an audit of patients' waiting times in 2014 (time from patients' arrival at the department on the day of their appointment to the time they were seen). This audit indicated that only 12% of patients were waiting for longer than 30 minutes. The audit did not indicate maximum waiting times and how these corresponded to the appointment times indicated on patients' letters. Patients did not complain about the time they were required to wait, excluding those in the oncology outpatient clinics who routinely waited for over an hour with maximum waiting times of 4 hours. We observed that when clinics involved multiple or timely tests this was indicated on a patient's appointment letter and in numerous leaflets so patients were aware of what to expect on their arrival and could plan their day accordingly. We observed that nurses and receptionists informed patients of the waiting times and which clinics experienced delays. Patients also told us they were provided with this information.
- The level of 'did not attend' at the hospital varied between 12% and 15% in 2014 was in line with the England average. We observed that this was relatively stable throughout the year. Staff managed patients not attending clinics by text and voicemail reminders. Voicemail reminders were sent five days prior to an appointment and a text reminder the day before the appointment.
- Paper referrals from general practitioners (GPs) were managed by the referral management centre (RMC), located at both sites of the trust (Guy's Hospital and St Thomas' Hospital). The RMC also received referrals from various departments and specialists at the hospital. They used an 'electronic vetting system to vet the suitability of the referral. The vetting system was accessed by the departmental secretaries who then allocated the referral to doctors for acceptance. Staff told us the system worked well and met the needs of the hospital. Managers told us the expectation was that consultants would triage referrals within 48 hours.
- Choose and book referrals (e-referrals) were managed by a separate team located at Guy's Hospital. If 'choose and book' appointments could not be managed within the 18 week timescales set the system used would alert appropriate staff so the referral could be managed outside of the choose and book system.
- Many of the clinical nurse specialists run their own, nurse-led clinics. For example menopause and early

menopause clinics as well as clinics in urology or orthopaedic clinics. It allowed improving access and freeing up doctors and improving the flow. Many of the clinics provided one stop services where patients had their consultations, blood tests and other tests done and results provided on the same day. Colposcopy was also a nurse-led service with three nurse colposcopists. The gynaecology outpatients department had two consultants involved in this field. The colposcopy service had British Society for Colposcopy and Cervical Pathology (BSCCP) accreditation.

- Women's follow up appointments at the gynaecology outpatients department were made on the day of their visit. Clinic cancellations were few. All administration including booking of surgery was carried out within the department. There was a coordinator who arranged the appointment date with the patient when a decision for surgery was made.
- The trust audited the time it took to send appointment letters and aimed to send them on the day of appointment booking or next working day for all services. The audit completed in July 2015 indicated that the average time to send a letter was 2.2 days with the quickest turnaround time in ENT and nephrology clinics (0.9 and 0.7 days respectively) and the longest in oral surgery (4.6 days), allergy clinics (3.5) and paediatric dentistry (3.4 days).
- On average, 7.5% of outpatient clinics' appointments were cancelled by the hospital (February to May 2015). The trust said the main reasons were doctors on annual or study leave. There was a policy that required doctors to give six weeks' notice before taking annual leave, to ensure that there was sufficient time to plan appointments around doctors' availability. Doctors we spoke to were aware of this policy.
- The trust had mostly met the national waiting time target of 18 weeks for non-admitted pathways (95% referral to treatment target [RTT] from April 2013 to August 2014. Those are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. The trust performed slightly worse than the England average between April 2013 and December 2014 and better than the England average in January and February 2015. It achieved the target in eight months of 2014. We noted that the longest waiting times were experienced in neurology (12 weeks; data for non-admitted pathways

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July 2015), gastroenterology (9.5 weeks), orthopaedics (8.5 weeks) and cardiology (8.5 weeks). Shortest waiting times were noted in geriatric medicine, ophthalmology and oral surgery (below 2.5 weeks in July 2015).

- The trust had consistently met the national waiting time target of 18 weeks for incomplete pathways. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month (RTT of 92%). The trust performed in line with the England average from April 2013 to February 2015. We noted that longest waiting times were experienced in plastic surgery, cardiology, trauma & orthopaedics, urology and gastroenterology (8.2, 7.3, 7.2, 6.4 and 6.2 weeks waits respectively; incomplete pathways data for July 2015). The shortest waits were recorded for geriatric medicine, oral surgery, rheumatology and gynaecology (below 4.6 weeks).
- The trust consistently performed in line with the England average in relation to the two week wait urgent referral performance target in every month since April 2013 (people seen by a specialist within two weeks from the time when an urgent GP referral was made; for all type of suspected cancers). We noted that the trust achieved 93% in April to June 2015 which was also similar to the England average. Suspected lung cancer (83%), brain and central nervous system tumours (85%) and upper gastrointestinal cancer (86%) performed worse than the trust average during the same period. Suspected head & neck cancer (95%), haematological malignancies (excluding acute leukaemia) and breast cancer (96% each), testicular cancer (98%) and suspected sarcoma (100%) performed better than average.
- Between October 2014 and September 2015, the trust performed better than the England average in relation to the percentage of people waiting fewer than 31 days from diagnosis to first definitive treatment (all cancers). They achieved 94.8% overall (October 2014 to September 2015) which was higher than the England average of 85%. We noted that in April to June 2015 the trust achieved 98% for all cancers non-admitted pathways and 93% for admitted pathways which was slightly worse than the England average (99% non-admitted and 97% admitted; 31 days).
- Between October 2014 and September 2015, the trust performed worse than the England average in every month from October 2014 to September 2015 in relation

to the 62 days target (percentage of people waiting fewer than 62 days from urgent GP referral to first definitive treatment; all cancers). They achieved 71% overall (October 2014 to September 2015) which was lower than the England average of 83.4%. We noted that in April to June 2015, the trust achieved 80% for all cancers non-admitted pathways and 65% for admitted pathways, which was worse than the England average (83% non-admitted and 81% admitted; 62 days).

- The trust told us breaches occurred due to an increase in referrals and because it was acting as a tertiary service for many of the specialties. It did not explain the lack of responsiveness and failure to meet the target since April 2013. We were also told that 45% of externally referred patients were referred post 42 days (patients on 62 days pathway) therefore the hospital did not have time to act within the set timescale. Although data analysed by us confirmed this, we noted that only 78% of patients internally referred had been treated within the required 62 days. The trust had identified issues within the head and neck, upper GI and thoracic specialties. They had organised a 'cancer risk summit' in April 2015 which involved commissioners, NHS England and local trusts working in partnership. This summit identified areas of focus and jointly agreed actions were set. The trust had prepared a working plan which forecasted the number of external referrals to ensure they were able to meet the demand. Breaches were analysed and it was identified that no harm had come to patients.
- The trust performed slightly worse than the England average (1.8%) in relation to diagnostic procedures waiting times with approximately 2.5% of patients waiting over six weeks for diagnostic tests (July 2013 to February 2015). Records indicated the longest waiting times in urodynamics (6 weeks; May to July 2015) and cystoscopy (4.4 weeks); both procedures were performed at Guy's Hospital. The shortest times were observed for DEXA scans (measuring bone mineral density; 1.3 weeks) and non-obstetric ultrasound (1.9 weeks). The average waiting time for other procedures such as MRI, CT, colonoscopy or gastroscopy was 2.6 weeks (May to July 2015).
- At the beginning of 2015 the trust identified a backlog in the reporting of plain film x-rays with a potential adverse impact on patients. This was reported to the commissioners as a serious incident. Much of the backlog related to the regulatory requirement that there



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should be formal reports to back up the contemporaneous interpretation of X-rays. The issue was resolved by the end of July 2015 after an action plan was implemented to ensure clearance of the backlogs.

- The trust monitored appointments that were cancelled more than once either by patients or by the hospital. This meant that the hospital was able to prioritise patients whose appointment had been cancelled on more than one occasion.

## Meeting people's individual needs

- Staff told us they had ready access to a translation service should they need it. This meant that patients, for whom English was not their first language, could engage fully in their consultation. We did not see any information leaflets for patients in different languages other than English. The census in 2011 highlighted that 2.3% of the borough's population spoke Spanish as their native language followed by Portuguese (1.3%) and Polish (1.2%), only 80% of the borough's population spoke English as their first language.
- 'Easy read' information leaflets and information in other formats, such as large font or braille, were not readily available. There was no information to advise patients where they could obtain such information. Staff were aware of this shortfall and told us they could provide relevant information on request. Patients could access all available leaflets related to various medical conditions online by accessing the trust's website
- Staff told us when patients with a learning disability or who were living with dementia attended the outpatients departments their carers were allowed to assist provided clear patient consent was given. They also ensured patients were seen quickly to minimise the possibility of distress to them. Many clinics had set days to provide appointments for people with a learning disability or dementia and spaced their appointment in such a way that they provided them with maximum time for their consultation and treatment.
- All outpatients and diagnostic imaging staff completed level 1 dementia training. In addition 13% of all nursing and medical and dental staff working at the hospital's outpatients clinics had received dementia awareness training level 2. It was lower than the expected 25% as per target set by commissioners. A similarly low number of staff working in clinical imaging and medical physics attended this training.

- There was drinking water available in the waiting areas and patients had access to refreshments if required.
- We observed that there was sufficient seating in most of the outpatient clinics. Clinics appeared well attended.
- There was sufficient equipment to provide support to people with mobility difficulties and bariatric patients. For example we saw a dental treatment room equipped with a specialist bariatric chair and a unit where patient on a wheelchair could be treated.

## Learning from complaints and concerns

- There were 291 complaints related to the outpatients department at Guy's Hospital in 2014/15. They included complaints related staff attitude, clinic time delays or cancellations and transport delays.
- Complaints were handled in line with the trust policy. Initial complaints were dealt with by the outpatient manager who resolved the issues either on a face-to-face basis if the complainant was available or by telephone. Where complaints were not resolved, patients were directed to the patient advice and liaison service (PALS). If they still had concerns following this, they were advised to make a formal complaint.

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

Good



Staff understood the vision of the trust and they could demonstrate how this was implemented in practice. Staff told us they enjoyed their work and that it made a difference to how patients felt about the hospital. Staff in all the outpatients' clinical areas we visited stated that their managers were visible and provided clear leadership. Staff and managers told us there was an open culture and they felt empowered to express their opinions and felt they were listened to by the management.

There was an effective system which mitigated risks through monitoring patient referral to treatment times and cancellations.

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## Vision and strategy for this service

- Staff understood the vision of the trust and hospital and they could demonstrate how this was implemented in practice. They told us they were proud to put patients first in everything they did and they strived to provide the best possible services to the local community.
- There were long term strategies in place for each of the divisions. These took into account the trust's goals and clearly highlighted key local priorities. It also allowed assessing long term risks related to finances and quality of the service such as clinical outcomes and patients' experience. Each division had a business plan which forecasted levels of activity and highlighted potential challenges. We saw that a strength and weakness analysis was undertaken to identify risks and opportunities.
- Staff were aware of the challenges they faced in their own service such as an increased amount of referrals or environmental constraints. They mostly felt they could participate in improving the trust's performance and patient's experience. Staff were aware of the key performance indicators set for their clinics and how they performed in relation to them.

## Governance, risk management and quality measurement

- The trust had adequate systems to monitor quality and performance.. Nurses and healthcare assistants working in the outpatient department told us audits and quality improvement projects were discussed with the staff. Data collected by the trust was mostly used to improve service quality and patients experience as well as to inform academic research.
- The trust's up to date performance indicators, such as appointment waiting times and those related to diagnostics, serious incidents, infection control, or financial performance, were easily available online in an easily accessible form.
- Governance arrangements were in place and staff were aware of them. Staff working in various departments and specialty areas were encouraged to attend and participate in governance meetings. Individual departments had regular clinical governance meetings and team meetings to discuss issues, concerns and complaints. All staff were given feedback about incidents and lessons learned during team or

departmental meetings. Comments, compliments and complaints and audits were standing items at governance meetings. We saw minutes of meetings that confirmed that these issues were discussed routinely.

- Clinical staff told us they were confident to raise concerns with their managers if needed and felt listened to and engaged in the development of the department.
- There was an effective system which allowed risks to be minimised through monitoring patients' referral to treatment times and cancellations.
- There were risk assessments related to radiation hazards and these were up to date and appropriately addressed potential risks.
- There were local risk registers for clinical imaging and diagnostic services and each of the specialties including medical, dental and GRIDA (genetics, rheumatology, infection, dermatology and allergy). These were reviewed in July 2015 and reflected potential risks to delivery of services. We noted that some of the risks, although reviewed regularly and some action had been taken to mitigate them, had been on the risk register for a long time. For example, medical specialties' risk register indicated the risk of harm due to delayed follow up for patients with glaucoma, cornea and paediatrics. It had been listed since August 2009. The risk of delay in providing care because of a lack of available notes had been listed since September 2008. There were many long standing risks on the GRIDA risk register including delays with histology results and reports in derma pathology due to poor IT tracking process listed since June 2009.
- For those using a patient transport services to attend clinic the hospital measured the time it took for a patient to leave after their outpatients appointments. The trust had set a target of 90% of patients to depart the waiting facility no later than 90 minutes after arrival in the waiting room and 95% no later than 2 hours. The hospital met both targets between June and August 2015.

## Leadership of service

- Staff in all the outpatient clinical areas we visited stated that their local managers were proactive and provided clear leadership. Senior managers were visible and were known to staff, were approachable and encouraged

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questions and suggestions from all staff. We noted that most managers were knowledgeable and very familiar with challenges faced by their departments and of overall performance both at local and trust level.

- There were clear lines of management responsibility and accountability within the outpatient's department. Staff in all areas stated they were well supported by their managers. They were visible and provided clear leadership. Most of the staff working within the outpatients and diagnostic imaging felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.

## Culture within the service

- All staff we spoke to were very proud of their work and services they provided to the local community. They were focused on providing a good experience for patients who visited their department. Staff and managers told us there was an open culture and they felt empowered to express their opinions and felt they were listened to by the management. Local teams worked efficiently and staff were supportive to one another.
- Doctors and nurses told us the communication between the different professionals was "excellent" and that it helped to promote a "positive working environment." Staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department. Staff and managers told us there was an open culture and they felt empowered to express their opinions and felt they were listened to by the management.
- Results of the NHS staff survey 2014 were very positive with the trust performing better than average in eight out of fourteen questions. Staff reported that they were satisfied with the quality of work and patient care (84%; 78% national average), and that they felt their role made a difference to patients (92%; 90% national average). This survey also indicated that there was a positive learning culture and effective and used by staff procedures for reporting errors, near misses and incidents.
- The trust launched its "speaking up" campaign at the beginning of 2015. Six hundred and fifty staff had

attended a workshop related to this campaign. Confidential phone lines and e-mail accounts had been set up and staff advocates were being trained so that staff were able to raise issues in confidence.

## Public and staff engagement

- We were told that staff meetings were held monthly and staff were updated on upcoming events, audits, appraisals, mandatory training, and conferences as well as were able to celebrate the achievements of the department. Staff publications and posters prepared for conferences were discussed among teams. We saw examples of posters that were presented at conferences and some that had won awards.
- Patients' views were obtained through a variety of surveys including friends and family tests, and national cancer patients' experience survey. The hospital routinely consulted patients when developing plans for significant service changes, and took their views into account when reorganising clinics. For example dermatology patients were surveyed before dermatology services moved from St Thomas' Hospital to Guy's Hospital in 2015 and their views were taken into consideration when designing clinics.

## Innovation, improvement and sustainability

- The Dental department was the largest outpatient specialty. The dental institute at Guy's Hospital trained the majority undergraduate and postgraduate dental students from the King's College London. The trust reported it was the largest dental school in Europe, training 20% of all dentists qualifying in the UK.
- St John's Institute for Dermatology was recognised as a national leader in genetic and skin disorders and a research centre which informed national guidance and innovative treatments. The trust also ran a large lupus clinic providing support to patients with systemic autoimmune disease (or autoimmune connective tissue disease).
- Guy's Hospital was the main site for the King's College London health schools, and home to the biomedical research centre and three Medical Research Council (MRC) Centres, including the MRC Centre for Transplantation.
- The hospital supported many research initiatives and participated in a variety of international clinical trials and research programs, such as those organised by The

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European Organisation for Research and Treatment of Cancer. Patients, through the national cancer experience survey 2014, reported that they were informed of research opportunities and clinical trials.

# Outstanding practice and areas for improvement

## Outstanding practice

- The SPCT was effective and provided face to face support seven days per week with visits up till 9pm and calls till 11pm and a consultant providing out of hours cover
- The Amber care bundle and a range of training courses for staff in end of life care such as the Sage and Thyme training model, Simulation days and Schwartz rounds.
- The Guy's Orthopaedic Outreach Team (GOOT): a fast track discharge and multi-disciplinary support service which improved patient outcomes and reduced length of stay.
- Proactive Care of Older People Service (POPS): an award-winning service and the first of its kind in the UK. The POPS service looks after patients aged 65 years and above to improve their medical health before and after surgery by assessing them before surgery, following their care while in hospital and supporting consultants and ward staff.
- The use of 'Barbara's story' to engage with staff and enhance a compassionate approach to patient care.
- Supportive practice of the mortuary and bereavement team.
- Staff in the bereavement office had sourced funding to provide family members with sympathetically designed cloth bags so they had a more discreet way of taking home personal belongings of a deceased patient, rather than use a plastic hospital property bag.

## Areas for improvement

### Action the hospital MUST take to improve

- Improve governance links between surgical directorates to ensure learning and concerns are shared across surgical directorates in a timely way.

### Action the hospital SHOULD take to improve

- Take steps to increase the number of day surgery cases to reduce bed demand and reduce length of stay. The trust should consider introducing a named day surgery clinical lead to improve coordination of day surgery and provide a single contact for surgical directorates.
- Take steps to improve the working culture within theatres to ensure that all theatre staff have fair access to learning and development opportunities.
- Continue embedding and monitoring use of the 'five steps to safer surgery' WHO surgical safety checklist, with a particular focus on pre-briefing and de-briefing.
- Ensure consent for surgery is clearly documented in patient records and patients are given adequate time and documentation to make decisions about their care in advance of their planned procedure date.
- Improve engagement with lifestyles teams in tertiary, secondary and primary care to help surgery patients with smoking cessation, weight loss or exercise programmes to improve local health outcomes.
- Review the process for completing DNACPR forms and determine a specific location where they are kept for end of life care patients .
- Improve the consistency of mental capacity assessments and the recording of them for patients receiving end of life care.
- Review the escalation process when delays occur with the completion of death certificates.
- Reduce delays in 31/62 days cancer waits (diagnosis and treatment) in Outpatients.
- In the outpatients department, ensure all staff are aware of protocols related to obtaining patients' consent; including protocols for those who might lack capacity to make a decision".
- Ensure all incidents in the outpatients department are investigated promptly and outcomes of the investigations recorded and shared with team to prevent recurrence.
- In the outpatients department, ensure all staff receive mandatory training and are appraised regularly as prescribed by trust's policies related to staff training and development.
- On Samaritan Ward, review the provision of toilet facilities for patients.
- Improve mandatory training completion by staff on the medical wards/departments.



## Outstanding practice and areas for improvement

- Improve performance on the number of patients starting treatment within 62 days for upper and lower gastro-intestinal illnesses.
- Ensure all staff, including staff working in outpatients departments, are provided with basic life support training.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**Governance links between surgical directorates were not effective, because learning and concerns were not shared across the directorates in a timely way. Regulation 17 (1)**

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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