Care Quality Commission

Guy's and St Thomas' NHS Foundation Trust

St Thomas' 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	Outstanding
Medical care	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Outstanding
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

St Thomas' Hospital is part of the Guys and St Thomas' NHS Foundation Trust (GSTT) which provides acute services to the population in the London boroughs of Southwark and Lambeth generating over 2 million patient contacts per year. The hospital has 920 beds and also acts as a tertiary referral centre in a number of specialties across the south of England including cancer services, cardiothoracic services and orthopaedics. The hospital also includes the Evelina London Children's Hospital.

GSTT employs approximately 12,586 staff of which 5560 are employed at St Thomas' Hospital.

We carried out an unannounced inspection of St Thomas' Hospital between 7th and 10th September 2015. We also undertook unannounced visits to the hospital on 21st,22nd,23rd and 26th September.

Overall this hospital is rated as good. Urgent and emergency services and services for children and young persons were rated as outstanding. Medical care, surgery, end of life care,outpatients and imaging, critical care and maternity and gynaecology were rated as good.

The compassionate and supportive nature of the care provided was rated outstanding as was the quality of leadership provided. Services were rated as good in terms of effectiveness and responsiveness, however the overall provision of safe care requires improvement.

Our key findings were as follows:

Safe

- There was an open and transparent approach to incident reporting that was supported by processes for reporting and the learning from incident investigations largely embedded.
- Both nursing and medical staffing levels and skill mix supported the provision of safe care and was well supported by a programme of mandatory training. Staffing levels in maternity services were reviewed annually and although there had been an increase in the antenatal day assessment unit staff found it hard to keep up with demand at times.
- Their were effective arrangements in place to minimise the risks of infection to patients and staff.
- Medicines and medical records were managed in an appropriately secure and monitored manner.
- Access to equipment and the quality of the physical environment were good with the exception of parts of the critical care service which was cramped with beds close together.
- Patient risk was well assessed across the trust, however the full five steps to safer surgery had not been fully embedded in operating theatre practice.

Effective

- Staff had ready access to and followed policies and protocols driven by accepted national guidelines and best practice.
- Multi-disciplinary teams were very well developed with a full range of health and social care professionals. In some areas, notably the urgent and emergency care department, the multi disciplinary teams were supplemented by further specialist teams including alcohol and toxicology support.
- Staff received appropriate appraisal and supervision and worked within a competency framework. Learning and development opportunities were provided for and specialist roles well developed in nursing.
- Patients were largely given timely pain relief following the application of appropriate pain scoring tools although we did identify some inconsistent documentation.
- Meal times were protected and well supported to ensure nutrition of patients. Similarly fluid intake was monitored to protect patients from dehydration.
- Consent processes and the documentation of mental capacity was largely good, however review of consent forms in surgery identified illegible recording.

Summary of findings

Caring

- Our observations and feedback from patients and carers indicated a kind, compassionate caring approach to the delivery of care. This was of particular note in children's services, critical care and end of life care where exceptional practice was identified.
- Patients reported that they treated with dignity and felt fully involved in their treatment and care.
- Services were well designed to provide emotional support to patients, carers and colleagues with access to counselling and spiritual support. Post bereavement support was of an exceptional standard in a number of services.

Responsive

- Services were well planned to meet the needs of the local population and co-ordinated with community and primary care services with the homeless team and the proactive older patients service examples of excellence.
- Patients were largely treated in timely manner meeting national access targets. However the trust had not attained the 62 day cancer access target since 2013.
- Services were designed to meet individual needs with the development of communication support for dementia and other complex patients very well developed. This was enhanced by the patient experience tale 'Barbara's story' which had clearly impacted on all staff and was extensively understood.
- Patient flow was well managed leading to minimal movement of patients between wards and a low numbers of surgical cancellations. Proactive discharge planning was well supported by the hospital at home team.
- The processes for the management of complaints and dissemination of learning from complaints were well developed although one surgical department had a significant number of complaints remaining unresolved.

Well-led

- The culture of organisation was highly positive, open and proud and was fully reflected in the high degree of engagement and empowerment of staff in service provision and improvement.
- Leadership within the trust was visible, supportive and collegiate and this, along with the organisational culture, contributed to the stability of the workforce in terms of recruitment, retention and low sickness levels.
- Robust governance arrangements were in place to monitor, evaluate and report performance and risk back to staff and upwards to the trust board.
- The trust vision and strategy was well communicated and understood and as a consequence directorate plans were fully aligned.
- The organisation encouraged and rewarded innovative practice and service development.

We saw several areas of outstanding practice including:

- The use of 'Barbara's story' to engage with staff and enhance a compassionate approach to patient care.
- The specialist support units active within the urgent and emergency department including alcohol, toxicology, homeless, youth support and play therapy for children.
- The role of the security team in the emergency department was embedded into the day to day working of the department. The team was multi-lingual and trained in effective de-escalation techniques and demonstrated outstanding empathy to patients.
- The provision of 'reflection time' to staff within the urgent and emergency department.
- The approach to communication with and support of dementia and complex needs patients via well designed communication boxes and a specialing team.
- The ward environment and signage afforded dementia patients.
- The Proactive Older Patient (POP) service.
- The multidisciplinary team support for families attending the neonatal unit.
- The paediatric cardiology service had introduced a home monitoring programme for infants following single ventricle palliation surgery (Norwood 1 operation or hybrid procedure). This allowed these patients to safely live at home with their families while they recovered and prepared for the second stage of their treatment.
- Supportive practice of the mortuary and bereavement team.

Summary of findings

- The SPCT was effective and provided face to face support seven days per week up to 9pm, with calls taken until 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.
- We saw 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.
- Staff in the emergency department had sourced funding and designed and produced a bereavement card that they sent to any families whose relative died in the department.

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

Importantly, the trust must:

- Ensure the quality and safety team coordinate and have oversight of all governance issues to improve learning and sharing across directorates.
- Ensure that all women attending maternity department receive a venous thromboembolism risk assessment.
- Ensure that appropriate levels of midwifery staffing are available in all areas so that women are cared for in the most appropriate environment.

In addition the trust should:

- Review barrier nursing arrangements within HDU and ensure the environment meets infection prevention and control guidance
- Ensure that the full 'five steps to safer surgery' are embedded in operating theatre practice.
- Continue reviewing and improving cancer performance.
- Ensure consent is clearly documented and patients are given documentation of the process. Implement the recommendations from the consent audit 2014.
- Ensure all complaints are responded to in a timely manner.
- Where appropriate utilise day surgery more to reduce the length of stay.
- Address areas of the national fracture neck of femur audit where the trust is performing below the national average.
- The hospital should ensure that staff are familiar with the mental capacity assessment process and that this is followed where appropriate.
- Ensure all staff are aware of safeguarding principles and triggers for making a referral
- Continue to increase consultant cover in maternity services.
- Ensure that telephone advice given to women in maternity services is documented
- Ensure there is a system in place to check that HSA4 notifications of termination of pregnancy for fetal abnormalities are submitted to the Department of Health.
- The hospital should consider reviewing the tools staff use to assess pain and introduce a standard methodology that is consistently used and recorded.
- The hospital should consider reviewing the process for completing DNACPR form, determine a specific location where they are kept and ensure staff are aware they can be used as an interim measure on discharge until the primary care team can complete a new one.
- The hospital should consider reviewing the escalation process when delays occur with the completion of death certificates.
- 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 and clinical imaging departments ensure all staff are appraised regularly as prescribed by trust's policies related to staff training and development
- The hospital should ensure staff are aware how to arrange for an interpreter.

Summary of findings

- The hospital should ensure that consultants review the results of local audits and implement strategies to ensure results continue to improve towards meeting CEM guidelines.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Outstanding ☆	The vision and strategy of the team working within the department was one of striving for excellence, which was demonstrated through a continuous programme of clinical and professional development. This was delivered by a cohesive, highly enthusiastic team that worked in a culture of mutual respect and trust. Our review of over 190 individual pieces of evidence and discussions with over 30 members of staff, revealed that the department was led by a team who embedded transparency and openness in the day-to-day working of the department. Staff were encouraged to report incidents and did so confident in the knowledge that learning would take place from them. Investigations into incidents and complaints were robust, impartial and emphasised service improvement. Although the ED had not consistently met the government's 95% target for admitting, transferring and discharging patients within four hours of arrival, staff had numerous procedures in place to mitigate the impact of this. The use of an effective streaming process for arriving patients had contributed to a very high performance in ambulance handover times, including no black breaches in the year leading to our inspection. Streaming and triage processes had been streamlined by a highly collaborative team that had conducted pilots and research to assess the safest and most efficient methods of registering and treating arriving patients. The drive and ability of staff to conduct on-going projects in order to improve the efficiency and quality of the service was evident in many other areas, including the flexible deployment of staff and a programme of specialist training that was highly regarded and facilitated by dedicated practice development nurses. The clinical effectiveness of the department was sustained by a substantial number of audits that were overseen by consultants and senior nurses. Audits demonstrated that consultant sign-off in severe sepsis and the management of neutropenic sepsis patients had improved from 2014 to 2015. Junior staff were encouraged to conduct audits in areas of interest to them and each nurse acted as a link for an area such as infection control or dementia.

Summary of findings

Most of the interactions we witnessed between staff and patients were positive and were based on compassion and respect. Where we saw that some individuals dealt with patients brusquely or without regard for their distress, senior staff had plans in place to address poor attitudes. We saw evidence that past approaches to dealing with such issues had been effective. Feedback we received from patients was mostly positive but some people did comment negatively on some of the unfriendly interactions we had seen. We considered such instances to be isolated and we found that the majority of patients held the ED in high regard, as evidenced from the frequent thank you letters and cards staff had received.

The ED was frequently presented with challenges to care and treatment based on the local population, including social care needs of homeless people and treatment needs for people who had overdosed on recreational drugs. Staff had led a number of innovative programmes to better support such patients and to improve their long-term health outcomes. Such approaches had led to substantive relationships with other local service providers, such as those who supported homeless people and those who experienced domestic violence. A well-established mental health liaison team was very highly regarded by the ED staff we spoke with and helped them to care for patients with psychosis and other mental health problems. We identified eight distinct projects that had been carried out by staff to help them care for people with complex needs whilst maintaining the overall clinical standards of the department. The projects served to enhance the scope of the service as well as to contribute to the feelings of achievement we found amongst staff.

The ED was undergoing a major rebuild that had changed the configuration and capacity of the current department. Plans and developments had been communicated to patients and staff had implemented a number of procedures to mitigate the impact of the building works. This had included a 24-hour streaming process and a 24-hour receptionist function in the majors unit. Staff had attended planning meetings with designers and architects to give their input into the new department design, particularly around the design of cubicles for patients with psychiatric needs. Consideration had been given to the treatment of patients who had learning difficulties or who were not

able to communicate verbally. In addition, a well trained and competent security team played a key role in the ED and enabled staff to treat patients with psychiatric needs safely. Staff had a good understanding of the Mental Capacity Act (2005), safeguarding procedures, dementia and their responsibilities for patients who had a Deprivation of Liberty Safeguards authorisation in place.

Medical care

Good

Overall we found medical care services at St Thomas' were good.

The safety of medical care services was good. There was a positive culture of incident reporting; staff understood and fulfilled their responsibilities to raise concerns and report incidents. We found measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited. We found there were sufficient doctors and registered nurses on duty; staffing levels were tracked four times a day across the hospital. Patients who were deteriorating received a speedy response and had their care reassessed.

We rated the effectiveness of medical care services as good. Staff were well supported with access to training, clinical supervision and development. Use of NICE guidance was used across a range of conditions. There was a programme of national and local audits regarding clinical practice in place. Patients were assessed by a dietician when screening suggested a risk of malnutrition.Patients' nutritional needs were assessed with scores recorded and risks identified. Consultants covering acute medicine 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.

We rated the caring aspects of medical care services as 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. Patients told us they were involved in decisions about their care and treatment and were given the right amount of information. The trust's performance in the Family and Friends test (FFT) was consistently higher had a higher than average response rate to the Friends and Family test (FFT) than the England average.

Summary of findings

We rated the responsive aspects of medical services as outstanding. The admissions ward was overseen by multidisciplinary medical teams who undertook assessments and provided a rapid response to reduce unavoidable admission and improve early discharge. The hospital proactively managed patients discharge. Where a patient's discharge was delayed this was escalated to the discharge team to progress. Most patients 79%, (21,405) 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.

We rated the well-led aspects of medical services as good. Staff were aware of the trust and acute medicine vision and incorporated this as part of their daily work. The culture within the division was one of openness and honesty. There was an appropriate system of clinical governance in medical services that identified quality and risk issues. Staff reported they were supported by their managers and department heads. We found staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

Surgery

Good

There were clearly defined vision and strategies for each surgery service that included working with other directorates and other organisations to provide the best health outcomes for all. There was strong clinical leadership with visible presence and nurses were empowered.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. Quality improvement was a part of all staffs daily roles and all staff were continuously striving to improve services.

Patients were supported, treated with dignity and respect and involved in their care and treatment. Patients told us that the care was kind, compassionate and they felt listened too. We observed a number of interactions where patients and their families were

involved in their care and helped with their emotional needs. The average response rate to the friends and family test was 35% with respondents most commonly recommending the service.
There were sufficient numbers and mix of all staff to provide safe care. There was good retention of nursing staff and management of turnover. There was a very low use of bank and agency nurses. Staff were qualified and had the skills and expertise to carry out their roles effectively in line with best practice. Care was coordinated and staff were worked collaboratively to understand and meet the needs of patients.
There had been nine never events in 12 months and we found the World Health Organisation (WHO) safer surgery checklist needed to always be fully used. However, although we found an open culture of learning from incidents, learning was not shared across directorates.
Staff were knowledgeable on the needs of their local population and service users. Access and flow was well managed by the service by working with the whole hospital. Waiting times and cancellations were minimal.

Critical care

Good

There was a proactive safety culture for reporting and learning from incidents. Critical care management were aware of on-going risks; these were recorded on the department risk register and largely reflected our inspection findings. Safety thermometer results and patient outcomes, particularly for patients receiving ECMO, were good. Patients were cared for by safe numbers of staff, using evidence-based interventions. Caring staff obtained consent prior to procedures and maintained patient privacy and dignity.
The critical care service was flexible to the needs of patients and successfully used a “never say no” admissions policy. Few patients were transferred out of hours and the proportion of delayed discharges from critical care was better than in other similar units. The critical care environment was cramped with little spacing between beds. However this issue was being addressed with a HDU rebuild and a new critical care unit. Staff and patients were engaged in developing plans for the new units and providing feedback about the service.
Substantial participation in national and international research projects was apparent and we saw evidence of many departmental contributions to journal articles,

book chapters and clinical guidelines. New innovations in critical care including telemedicine were being trialled and plans for formal implementation were in place.
Staff knowledge of safeguarding and Deprivation of Liberty Safeguards (DoLS) was variable across the service despite a high uptake of training in this area and safe practice relating to this 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.

Maternity and gynaecology — Good

We rated the maternity and gynaecology service as good, but some aspects of maternity services require improvement.
Women's services promoted innovation and encouraged their staff to provide responsive and woman-centred care and treatment. Staff were proud of working for the trust and felt they were able to contribute to improving services. Multidisciplinary teams of professionals with a range of knowledge and skills provided outstanding treatment and care for women with specialist needs, such as pregnant women with lupus, and women with endrometritis.
Staff gave women information and encouraged them to be involved in making choices about their care. Pregnant women were able to make choices about the birth they wanted.
The Antenatal Day Assessment Unit (ADAU) was often full to capacity and women sometimes had to wait a long time to be seen. Births that took place on the ADAU were not reported as incidents unless there were complications with the delivery.
We found there was some confusion among midwives about whether or not all women needed to have a venous thromboembolism (VTE) risk assessment.
Staff told us management encouraged openness. Incident reporting had increased, and there were systems in place for reviewing, investigating and learning from these. There was evidence of changes to practice following incidents. There was a trigger list of maternity incidents, but we did not find a shared understanding of other incidents to be reported. For example, staff shortages were not always logged on the

incident reporting system. Furthermore, we found that incidents were recorded as 'low harm' even when women or their babies were transferred for additional care.
Gynaecology services gathered evidence about their services to make business cases for improvements to safety and responsiveness. For example the trust had agreed to increase consultant presence at the emergency gynaecology unit. The maternity service, however, did not have the recommended levels of consultant cover, and although this had been on the risk register since 2010, there had been no increase in the number of consultants at the time of our inspection.
Policies and treatment protocols were informed by evidence based national guidance. Gynaecology and maternity services participated in a number of leading edge research projects and their practice was informed by research findings. Staff ran projects to test new ways of working, for example a project to give early warning of women liable to have a pre-term birth.
There was a programme of audits but the programme required further development.. Outcomes for women were and babies were generally in line with or exceeded national expectations. However, the rate of caesarean sections was worse than the national average and action to reduce this had not achieved sustained improvement. Gynaecology clinics met targets for referral to treatment times.
There was effective working with other specialties in the trust and with local commissioning groups and GPs.
Staff of all disciplines reported good team support and learning and continuing professional development. Line managers supported nursing and midwifery staff, and the supervisors of midwives provided regular review and additional training. Junior doctors at all levels felt supported by the consultants and registrars

Services for children and young people

Outstanding ☆

We rated the hospital services good for safety. There was a robust and open process for ensuring that clinical incidents were reported and investigated and that lessons learnt from them were fully shared with all staff. Robust safeguarding systems were in place. Patient risks were appropriately identified and acted upon with clear systems in place to identify and manage a baby, child or young person's with a deteriorating medical condition.
We assessed the effectiveness of care provided as good. There was participation in audits and care and

treatment was provided in line with professional guidance. The hospital was effective at coordinating its multi-disciplinary teams to ensure the best outcomes for patients. While not all services operated seven days a week, services were flexible to meet patients' needs.

We rated the care provided as outstanding. We saw many examples in all areas of the hospital to demonstrate that the hospital was delivering compassionate care. Parent feedback unanimously supported this. Sensitive emotional support was offered to patients, parents and staff. Parents told us they had a good understanding of the care their baby or child was receiving and felt the hospital involved them in the care their children received. Friends and family test outcomes were also highly complimentary of the service. Children and their families were treated with compassion, dignity and respect.

We rated the responsiveness of the service to the needs of patients and their families as good overall, although there were some elements that were outstanding. We found many examples where the hospital and its staff had made special efforts to meet the needs of children, young people and their families. Examples of initiatives were a fasting reduction initiative for children having surgery, communication boxes on wards to help communicate with nonverbal children or those who did not speak much English, and clinics being timed so secondary school children would not miss too much school. Joint clinics were organised so that young people could meet their ongoing care team to help ease the transition to adult services. However, there were challenges in meeting referral to treatment times in some specialities, and dealing with year on year increases in demand with limited scope to increase capacity in the medium term.

Complaints and concerns were taken seriously. They were responded to promptly to achieve resolution. Feedback was actively sought from parents, children and young people about their current care experience, and where possible changes to improve the quality of care were introduced in response to suggestions.

We found leadership in ELCH to be outstanding. The vision to establish Evelina as a comprehensive specialist children's hospital within a regional clinical network was well understood and supported by staff.

The hospital had a strong clinical governance structure, focused on reducing clinical risk, monitoring quality and

improving patient outcomes. There was committed,supportive leadership at local, service and hospital levels, and clear reporting lines for escalating risk, disseminating information and monitoring standards, We found an open and transparent culture with motivated and compassionate staff who were well informed about the hospital's priorities as well as those of the wider trust, and felt they had a genuine role in shaping the development of the hospital. Staff valued the democratic culture and were passionate about supporting children and their families through sickness,. There was an ethos of continuous improvement. Families and patients also felt involved in developing the hospital through consultation and effective communications.

End of life care

Good 

Staff who worked in the specialist palliative care team (SPCT) demonstrated a multidisciplinary approach to caring for their patients.
They worked cohesively with generalist nurses and medical staff, respecting each other's skills, experience and competencies in a professional manner that benefited the patients they cared for.
Staff at St Thomas' 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, with staff commenting on how senior managers were visible, approachable and willing to help out. They also provided consistent and prompt guidance and support.
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. We saw 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 was in its infancy and staff

commented that it needed to be revised and made more achievable. Nevertheless staff spoke very positively of the multi-disciplinary team approach; the importance of quality outcomes for patients and the focus on providing care that was based on individual need. We saw, for example, that staff had arranged for the painting materials belonging to one patient nearing the end of life to be brought to the ward so they could continue with their art. 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 referred to the NICE quality standards for end of life care.

Bereavement support was available from the SPCT social workers, chaplaincy and the bereavement office. We saw patients were cared for with dignity and respect. Medicines were provided in line with guidelines for end of life care. Staff facilitated rapid discharge of patients to their preferred place of death. 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 that in some patients' notes their condition indicated a mental capacity assessment would have been appropriate but staff had not carried one out. We were told there were sometimes delays in relatives being issued with a death certificate due to the unavailability of doctors to complete the paperwork.

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, they were not always responsive to patients' needs.

There were long term strategies developed for individual departments and staff were aware of them. Staff felt

Summary of findings

they could influence decisions made in relation to day to day running of their department and felt empowered by their management. The hospital had effective governance systems and healthy organisational culture of openness and transparency. Staff were happy working at the hospital and were provided with appropriate support to allow them to perform their work effectively.

Patients' care was well organised, with individual patients being discussed during multidisciplinary team meetings. Patients told us they felt involved in their care and that they were treated with dignity and respect. They also felt involved in decisions about their care and treatment.

There was a sufficient number of nurses and medical and dental staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required. Staff knew how to report incidents and raise a safeguarding alert, they were encouraged to report incidents and received direct feedback from their line managers. Staff told us they were able to share concerns openly. Staff were competent and had had appraisals within the past twelve months. They had access to information in order to support decision making and offer appropriate care and treatment.

The trust had met the national waiting time target of 18 weeks for non-admitted and incomplete pathways. The trust had also consistently performed in line with the England average in relation to the two week wait urgent referral performance target. The trust had systems which allowed gathering data, they were able to analyse it to identify risks and prioritise patients accordingly to clinical need.

However, we noted 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.

St Thomas' Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to St Thomas' Hospital

St Thomas' Hospital is part of the Guys and St Thomas' NHS Foundation Trust (GSTT) which provides acute services to the population in the London boroughs of Southwark and Lambeth generating over 2 million patient contacts per year. The hospital has 920 beds and also acts as a tertiary referral centre in a number of specialties across the south of England including cancer services, cardiothoracic services and orthopaedics. The hospital also includes the Evelina London Children's Hospital.

GSTT employs 12,600 full time equivalents (FTE) staff of which 5560 are employed at St Thomas' Hospital.

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, assistant 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

Detailed findings

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

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 St Thomas' Hospital

Context

- St Thomas' 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, maternity and outpatient clinics. The hospital includes the Evelina London Children's Hospital.
- 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 920 beds including 65 critical care beds and 200 paediatric beds (Evelina London). In 2014/2015 there were 6,865 births.
- The hospital employs 5,5560 Full Time Equivalent (FTE) 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.
- In 2014/15 there were 26,779 medical inpatient admissions and 23,813 surgical stays of which 45% were day case activity.
- There are approximately 572,000 outpatient appointments per annum.
- The emergency care department saw 182,720 adults and 24,000 paediatrics during 2014/15.

Key intelligence indicators

Safety

- Most of the following information was produced at trust level only.
- Nine never events were reported by the trust between September 2014 and August 2015. 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 seventy six serious incidents at St Thomas' 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

- The following information was produced at trust level only.

Detailed findings

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

Caring

- The following information was produced at trust level only.
- From the CQC inpatient survey 2014, this trust performed about the same as other trusts for all questions.

Responsive

- Most of the following information was produced at trust level only.
- Between June 2014 and June 2015, the trust received 934 complaints.
- 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

- The following information was produced at trust level only.
- 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 St Thomas' 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	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Medical care	Good	Good	Good	☆ Outstanding	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
End of life care	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	☆ Outstanding	Good	☆ Outstanding	Good

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at St Thomas' hospital provides a 24-hour, seven-day a week service. Overall the ED saw 182,720 patients in 2014/15 and the paediatric ED saw 24,000 patients in 2014/15. In 2014/15, 18.1% of ED attendances resulted in admission and 83% of patients were 17 years old or older.

The ED consists of 28 major treatment beds, a five-bedded resuscitation area with a paediatric resuscitation bay, an urgent care centre (UCC) with six assessment bays and an eight-bedded paediatric emergency unit. The paediatric unit had 9512 attendances from January – May 2015 and had two cubicles for minor injuries or illness and one triage cubicle. There is also a separate emergency eye unit and a tertiary hand plastics plastic unit available. An emergency medical unit (EMU) with 16 beds provides support to the ED by looking after patients for up to 24 hours after they attend A&E while they wait for test results and further assessment. Two x-ray units and a CT scan are available. ED clinical staff are supported by a team of 28 receptionists and administrators.

Patients present to the area by walking into the reception area or arriving by ambulance. Patients who arrive on foot are greeted by a nurse streamer who conducts a brief initial assessment so they are seen in the most appropriate part of the department. This process ensures that patients who need immediate analgesia are offered it and that immediate blood tests, electrocardiograms and urinalysis can be done in one of the initial assessment bays. Nurses have also been trained to order x-rays. If the person's condition is not immediately serious, they are directed to a reception desk to give more detailed information. A nurse will then 'stream' them to the most appropriate unit in the department. If the patient arrives by ambulance, they are booked into the majors area and an initial assessment is completed there. Patients are then transferred to the appropriate area.

During the hours of 0900 – 1700 Monday – Friday, patients can be directed to a local GP surgery where they will be seen without the need for a previous registration at the practice. This helps the ED to reduce the pressure on its services and to reduce the waiting time for patients who need to be seen in the department. Where a paediatric patient presents at the reception desk, they are directed to paediatric ED for triage.

Urgent and emergency services

Summary of findings

Overall we have rated the Emergency Department (ED) as outstanding. The vision and strategy of the team working within the department was one of striving for excellence, which was demonstrated through a continuous programme of clinical and professional development. This was delivered by a cohesive, highly enthusiastic team that worked in a culture of mutual respect and trust.

Our review of over 190 individual pieces of evidence and discussions with over 30 members of staff, demonstrated that the department was led by a team who embedded transparency and openness in the day-to-day working of the department. Staff were encouraged to report incidents and did so confident in the knowledge that learning would take place from them. Investigations into incidents and complaints were robust, impartial and emphasised service improvement.

Although the ED had not consistently met the government's 95% target for admitting, transferring and discharging patients within four hours of arrival, staff had numerous procedures in place to mitigate the impact of this. The use of an effective streaming process for arriving patients had contributed to a very high performance in ambulance handover times, including no black breaches in the year leading to our inspection. Streaming and triage processes had been streamlined by a highly collaborative team that had conducted pilots and research to assess the safest and most efficient methods of registering and treating arriving patients. The drive and ability of staff to conduct on-going projects in order to improve the efficiency and quality of the service was evident in many other areas, including the flexible deployment of staff and a programme of specialist training that was highly regarded and facilitated by dedicated practice development nurses.

The clinical effectiveness of the department was sustained by a substantial number of audits that were overseen by consultants and senior nurses. Audits demonstrated that consultant sign-off in severe sepsis and the management of neutropenic sepsis patients had improved from 2014 to 2015. Junior staff were encouraged to conduct audits in areas of interest to them and each nurse acted as a link for an area such as infection control or dementia.

Most of the interactions we witnessed between staff and patients were positive and were based on compassion and respect. Where we saw that some individuals dealt with patients brusquely or without regard for their distress, senior staff had plans in place to address poor attitudes. We saw evidence that past approaches to dealing with such issues had been effective. Feedback we received from patients was mostly positive but some people did comment negatively on some of the unfriendlyabrupt interactions we had seen. We considered such instances to be isolated and we found that the majority of patients held the ED in high regard, as evidenced from the frequent thank you letters and cards staff had received.

The ED was frequently presented with challenges to care and treatment based on the local population, including social care needs of homeless people and treatment needs for people who had overdosed on recreational drugs. Staff had led a number of innovative programmes to better support such patients and to improve their long-term health outcomes. Such approaches had led to substantive relationships with other local service providers, such as those who supported homeless people and those who experienced domestic violence. A well-established mental health liaison team was very highly regarded by the ED staff we spoke with and helped them to care for patients with psychosis and other mental health problems. We identified eight distinct projects that had been carried out by staff to help them care for people with complex needs whilst maintaining the overall clinical standards of the department. The projects served to enhance the scope of the service as well as to contribute to the feelings of achievement we found amongst staff.

The ED was undergoing a major rebuild that had changed the configuration and capacity of the current department. Plans and developments had been communicated to patients and staff had implemented a number of procedures to mitigate the impact of the building works. This had included a 24-hour streaming process and a 24-hour receptionist function in the

majors unit. Staff had attended planning meetings with designers and architects to give their input into the new department design, particularly around the design of cubicles for patients with psychiatric needs.

Consideration had been given to the treatment of patients who had learning difficulties or who were unable to communicate verbally. In addition, a well trained and competent security team played a key role in the ED and enabled staff to treat patients with psychiatric needs safely. Staff had a good understanding of the Mental Capacity Act (2005), safeguarding procedures, dementia and their responsibilities for patients who had a Deprivation of Liberty Safeguards authorisation in place.

Are urgent and emergency services safe?

Good

There were robust systems and protocols in place to protect patients and staff from risk. The Royal College of Nursing (RCN) baseline emergency staffing tool was used to ensure there were sufficient numbers of staff based on patient acuity and demand on the service. Staff worked flexibly across the various units in the department and could be redeployed in response to a change in demand. Staff received on-going and extensive training to enable them to carry out their roles effectively.

The reporting of accidents and incidents was commonplace and staff said that the transparency of the reporting and investigation processes gave them confidence that safety and practice was always improved with learning from an incident.

Well-established processes were in place for when patients first arrived in the department. Monitoring for patients who were in the department for extended periods of time was led by consultants and senior nurses and specialist referral pathways were clear and used without delay. Escalation plans that included senior doctors, managers and nurses were used to reconfigure the service during times of high demand and ensured that the most serious patients were dealt with as a priority.

Incidents

- There were two serious incidents reported to the National Reporting Learning System in 2014/15, both of which were grade three pressure ulcers that patients had presented with on arrival at the department.
- Mortality and Morbidity meetings took place monthly as part of the department's internal governance system and were led by the lead ED consultant.
- There was a consistent and reflective approach to learning from incidents that supported staff in investigating how an incident had occurred. This was always followed with staff collaboratively exploring strategies to reduce the same issue occurring again. The lead emergency nurse practitioner (ENP) had conducted detailed root cause analyses following each incident in the main ED and there was evidence that policies and practice had changed as a result. For instance, following

the inappropriate initial treatment of a patient with a broken hip, a clearer streaming process was introduced. This meant that people attending the ED in a wheelchair, who were not able to provide a medical history or who were not able to communicate clearly in English were given additional assessments. A nurse told us, "The incident reporting culture here is very good. It's all about teaching, even when you see someone else's error. The no blame culture is very much embedded, there's always something to be learned."

- Staff told us that development days were used to discuss incidents and learning from them, which we saw by looking at the minutes of meetings and the agendas for staff days. Incidents were reported using the Datix system, which provided a tracking system for staff to check on the status of their submission.
- Incidents that had occurred in the emergency medical unit (EMU) were investigated and areas for learning were communicated to staff. For instance, patients were routinely offered a hospital gown or pyjamas after an incident involving inappropriate clothing. A more effective communication policy was implemented between the unit and the transport manager after a patient missed an important appointment because of a delay with transport.
- The ED had a dedicated security team that was based in the initial registration area. The team provided a 24-hours, seven-day service to the department. Each member of staff carried a silent alarm on them that could be used to summon a member of security staff in an emergency. There was a weekly meeting between security officers, ED nurses and the trust police officer to discuss incidents of violence or aggression. The meetings had been used to highlight best practice for clinical staff when dealing with agitated or angry patients. Patients who had been removed from the department for attacking or abusing staff were sent a letter explaining why their behaviour had been unacceptable. This had resulted in a number of letters of apology being written to staff and a reduction in the number of repeat attendances by violent individuals.

Duty of Candour

- Staff we spoke with were able to tell us in detail about their understanding and responsibilities of the Duty of Candour. Where an error or incident had occurred, doctors and nurses had been proactive in discussing this with patients and their relatives where appropriate. We saw that learning had occurred as a result of such errors and that the Duty of Candour had been used to further improve practice. For instance, when a penicillin error had occurred, the member of staff involved had realised in time to phone the patient and prevent them taking the first dose. Following a learning exercise, medicine charts had been created that displayed drugs with similar-sounding names. The charts had been displayed prominently in prescribing areas and acted as a reminder to staff.
- The electronic incident reporting system prompted staff to speak with people involved under their Duty of Candour responsibilities. We saw that staff had to acknowledge their understanding of this before an incident record could be submitted. Staff had involved other departments in the hospital and external specialists where necessary to ensure that patients or family members were kept informed of incidents. For example, a renal specialist from outside the trust assisted in the investigation of an incident where there had been a delay getting a patient to intensive care and their relatives had been kept informed.

Cleanliness, infection control and hygiene

- Staff undertook cleaning audits that checked cleaning and infection control standards against the National Patient Safety Agency National Cleaning Standards. The frequency of audits was based on the level of risk in each area. For example, areas of high risk were audited on a monthly basis and areas of significant risk were audited every three months.
- We observed that staff followed trust policies and procedures for infection prevention and control (IPC) and hand hygiene. This included wearing the correct personal protective equipment such as gloves and aprons.
- There was an infection prevention and control link nurse who was given dedicated time each month to complete IPC audits.
- We saw that sStaff washed their hands between each patientbetween and we saw that the use of hand sanitising gel was standard practice across the department. This gel was available at all exit and entry points and signs encouraged visitors to make use of it.
- The most recent audit data of staff practice available to us was from March - June 2015 and included compliance checks on nurses, doctors, allied health professionals and healthcare assistants at five stages of

patient contact: just before contact, before an aseptic task, after patient contact, after contact with a patient environment and after a body fluid exposure risk. Overall compliance was 74%, with 100% compliance across all staff in adhering to the policy of no nail varnish and covering cuts and grazes with a waterproof dressing. An area for improvement was staff decontaminating their hands using the correct technique, which demonstrated 78% compliance. Actions to address this had included hand hygiene training during doctor induction and annual IPC training for nurses.

- There were two link nurses who completed local cleaning and hand hygiene audits. To ensure fairness in the audits, the link nurse for adult ED would complete the audit for the paediatric unit and the link nurse for the paediatric unit would complete the audit for adult ED areas. The results were widely disseminated to staff using a noticeboard, individual e-mails and a communication book and staff completed an action plan where areas for improvement were identified. For instance, the latest trust cleaning audit for ED functional areas in June 2015 had indicated 95% compliance, with areas of nursing responsibility achieving 73%. This was a 15% reduction from the previous audit the subsequent action plan had led to compulsory training for nurses on cleaning processes, a new cleaning checklist for use overnight and a daily visual inspection of the ED by the nurse in charge. .
- Hand hygiene audits for May – July 2015 showed an average compliance with trust policy of 77%. Housekeeping staff were present in the ED 24-hours, seven days a week and we saw the housekeeping supervisor conduct regular inspections of clinical and patient areas.
- The ED had no reported cases of MRSA or C.Diff in the year to our inspection.

Environment and equipment

- The ED was undergoing a major rebuilding project that included a reconfiguration of the whole department with all units facing significant refurbishment and change. We saw that patients and staff were protected from the risks of building works with hoarding that separated areas of construction from corridors and clearly displayed safety protocols.
- The department had a wide range of specialist equipment, which was clean and well maintained. Labels were in use to indicate when items of equipment had been cleaned. Labels were also used to indicate when equipment had been reviewed for safety. Most equipment had undergone a safety check in the last year although a manual blood pressure machine had no documented check since December 2012 and a scanner in a resuscitation bay had been due for a formal annual test in November 2014.
- Staff told us that they checked equipment daily and we saw that they did this in practice. Where equipment was found to be defective, this was noted in the nurse in charge report that was completed every shift and was escalated to the appropriate department.
- Staff we spoke with told us that they had received special training on the safe use of each item of equipment and that they were confident using it.
- We saw that where equipment had been used incorrectly, notices were displayed on a dedicated notice board to support staff. For instance, a notice relating to the correct use of suction equipment in the resuscitation area had been displayed that gave staff detailed information on its use and where they could find more help if needed.
- The waiting areas in the ED were bright, airy and well maintained. Staff had given thought and attention to how these were laid out to avoid any discomfort to patients during the rebuilding works.
- The resuscitation area was clean, tidy and well organised. This included a paediatric resuscitation bay, which had the appropriate specialised equipment to resuscitate children.
- The location of the resuscitation unit was conducive to the rapid transfer of patients from incoming ambulances to the care of the emergency team.
- The majors unit had a bay that was suitable for the treatment of patients under police escort or who presented with psychiatric needs. This room could be secured to protect the patient and staff from harm. Staff from the mental health liaison team raised concerns that this room was not fit for purpose. One member of staff said that it was not well maintained or cleaned regularly enough and that staff used it inappropriately, such as for intoxicated patients rather than those who had definitive mental health needs.
- The paediatric emergency unit was brightly decorated and had toys and visual stimulus appropriate for young children.

- The majors unit had a lack of space for the volume of patients seen there and eight doctors we spoke with told us that crowding of the area was a concern.
- Senior staff had been able to bid for new equipment from competitive budgets and had been successful in this. New cardiac monitors and transfer monitors had been delivered in 2014 as a result of successful bidding and three trauma mattresses for the immobilisation of c-spine patients had also recently been delivered.
- Resuscitation trolleys had been recorded as being checked daily and were easily accessible.

Medicines

- Medicines were stored and accessed using an electronic Omnicell system. Each member of staff that had been trained in the administration of medication had a password that would allow them to access medicines using this system.
- Controlled drugs (CDs) were stored and administered in line with National Institute for Health and Care Excellence (NICE) guidance, including the double locking of cupboards and the practice of two nurses checking-in CDs. A record of the signatures of staff authorised to give out CDs was maintained and had been updated monthly.
- Stock checks of CDs were completed twice daily, including patients in resuscitation who had arrived with their own CDs. A pharmacist checked the stock of CDs on a weekly basis.
- A local protocol for the administration of antibiotics was available electronically and staff we spoke with were able to show us how they could access this quickly.
- Agency nurses working in the department were required to complete a medicines administration declaration that checked their competence and enabled them to administer oral medications as well as provide evidence of their certification in the administration of IV therapy and CDs. Agency nurses were accepted on a minimum contract of three months that enabled them to become familiar with department policies and operations and contribute consistently to the permanent team.
- Where medicines were prescribed in the urgent care centre, two staff nurses checked the dosage and signed for them according to a doctor's prescription.
- The recording of daily temperature checks for medicine fridges was not consistent, with 18 days missed between July and September 2015.
- A pharmacist provided training for the ED practice development nurses (PDNs) and staff told us that he was readily accessible whenever they needed help. Two nurses were designated links for drugs and medicines.
- All nurses undertook a medicines assessment when they started working in the department, which included a set of competencies in line with NMC guidance.

Records

- We looked at the care records of 32 adults and 15 paediatric patientspeople during the inspection to check if the department was routinely conducting risk assessments in the context of falls, safeguarding and mental health assessments, as well as in relation to pain relief needs. We found the records to be complete in all cases. All paediatric patients had a recorded child protection assessment and an initial pain score. Practice Development Nurses (PDNs) conducted a monthly audit of patient records for completeness and a weekly audit was undertaken to ensure that paper records were being scanned onto the electronic patient tracking system promptly. Learning from such audits were presented to staff during morning handover sessions.
- Paper records, or CAS cards, were used in the ED, including the EMU, for the recording of initial registration and the recording of some observations and treatment records. Electronic records were used to record patient care assessment plans as well as specialist information such as falls prevention risk assessments and tissue viability assessments. Staff told us that when the department's rebuild was completed, they planned to have a fully electronic patient records system in place, with the current paper records discontinued.
- Staff used the situation, background, assessment and recommendation (SBAR) tool to record observations while awaiting test results.
- We saw that staff were aware of the sensitivity and confidentiality of patient records and that they were not left out in public areas. An incident had occurred in the EMU whereby patient notes had gone missing and senior staff there had implemented changes to the handling of paper records to prevent this from happening again.
- Patient care records included allergies, an assessment of pressure areas if applicable and evidence that a senior nurse had reviewed them and referred them to an appropriate doctor.

- We saw that safeguarding the child checklists were completed routinely for every patient, including a child protection assessment.

Safeguarding

- A mental health liaison team, including psychiatric liaison nurses (PLN), a registrar and a consultant worked with the ED team to provide specialist mental health, safeguarding and capacity assessment support. This team provided a 24-hour, seven-days a week on-call service that supported the ED in issues relating to safeguarding, such as in suspected cases of abuse. A PLN was based in the ED overnight to provide a rapid response service. Staff we spoke with were unreservedly positive about the support they received from the team.
- All registered nursesstaff working in the paediatric ED had undergone child safeguarding training to level two as a minimum, with annual updates, and 88% of nursing most staff had undertaken level three child protection training. All middle grade doctors and consultants in the ED had been trained to level three in paediatric safeguarding. Junior FY2 doctors had received level two child protection training focussed specifically on emergency care.
- There was a robust policy in place for identifying safeguarding issues with children. This included an initial check of electronic records to identify if the child had a protection plan from one of the three local authorities served by the unit. Where a child was out of their local area, staff would determine why they had not attended their local hospital. We saw that safeguarding the child checklists were completed routinely for every patient, including a child protection assessment.
- Staff had access to a nurse specialist in female genital mutilation (FGM) who provided an on-call service in suspected cases.
- Weekly multi-disciplinary safeguarding meetings took place to discuss incidents and referrals.
- 100% of nursing staff had undergone safeguarding training or refresher training to level three in the previous year .

Mandatory training

- The ED had two dedicated practice development nurses (PDNs) who were responsible for planning mandatory training for staff. They maintained a training matrix that was used to track staff training dates and refresher dates using the trust-wide 'Wired' system. This also enabled the PDNs to plan in advance to ensure that training certification would not expire. The department met the trust's target for up to date staff training in all areas of mandatory training. For instance, 97% of A&E nurses and 100% of UCC staff were trained in medicines management that had been delivered using the Nursing and Midwifery Council (NMC) Code of Professional Conduct. 85% of nurses had up to date training in fire safety, infection prevention and manual handling. Health and safety, safe transfusion and basic life support were included in nurse mandatory training.
- Mandatory training had annual refresher updates, such as safeguarding level three, major incident training and child protection level three. Weekly development days had included topics such as initial assessment and triage, trauma, plaster of Paris, sutures and nurse-requested x-rays. Staff competence was checked initially by their performance in training and then by observations from senior staff. Training included the results of audits completed by staff to highlight areas of good practice and where improvements could be made. Staff at band sixsister grade and above had been trained in advanced life support and had undergone advanced trauma training.
- Nursing staff we talked with spoke highly of their mandatory training opportunities and experiences. All band six nurses had to hold an ED course certificate and have completed a mentorship course prior to their appointment..

Assessing and responding to patient risk

- From January 2013 to February 2015 the trust did not meet the 60-minute time to treatment target. In 2014/15, for patients arriving on foot, the time to receive an initial clinical assessment was most often between six and eight minutes, with four occurrences of a mean wait time up to 12 minutes. In the same period the trust did not always meet the 60-minute time to treatment target. In the first quarter of 2015/16, the median time to treatment was one hour and seven minutes.
- Reception staff had been trained in the use of a first contact protocol that enabled them to ensure high-risk patients were seen more quickly, such as children with a fever or a person with chest pain. By also being trained to visually scan the waiting areas, receptionists were able to identify any patients who may be exhibiting

symptoms that meant they should be seen more quickly. Reception staff did not triage patients and supported nursing staff after they had been received in the department.

- ENP staff and doctors working in the UCC had engaged with the Urgent Care Network to ensure their practice maintained safety standards as attendance numbers increased.
- Where a child presented with an injury, staff were trained to ask 'trigger' questions of the child themselves to find out what had caused the injury. The paediatric registrar paediatric emergency consultant were contact when ED staff had a concern about child safeguarding. The trust's urgent and emergency care child safeguarding policy included criteria under which staff would refer a child to the paediatric registrar such as an unexplained skull fracture, self harm, genital injury or if staff suspected domestic violence. Senior paediatric staff would also be contacted if a child was identified as a frequent attender. Staff would contact children's social care whilst a child was still in the department if they suspected a safeguarding problem and the trust's policy included guidance for staff on who should be contacted for urgent support.
- The lead ENP ensured that information about ED services available to 111 call-handlers was updated regularly to ensure that the advice they gave to people regarding emergency hospital attendance was up to date and appropriate.
- The time from a patient arriving in an ambulance to receiving initial treatment was better than the England average in all but two months between January 2013 and January 2015. In all cases patients had waited less than 10 minutes for an initial assessment.
- A London Cancer Alliance audit of neutropenic sepsis patients indicated that in 2014/15, patients were administered antibiotics within 50 minutes of arrival.
- A rapid assessment and treat (RAT) nurse worked in the ED to provide support to the team in majors and was able to work flexibly across the department to provide additional capacity for complex or urgent cases. The nurse worked to a process that included the assessment of deteriorating patients using the national early warning score (NEWS) system. Patients with a NEWS score of six or above would be seen by a RAT nurse and assessed for admission to the resuscitation unit. We saw that this worked well in practice. Various RAT models had been tested in the ED to assess the most efficient, safest approach to use. A roving model was in use when we visited, which meant that the nurse could be deployed where they were most needed.
- Paediatric and adult emergency medicine patients had access to 24-hour reporting by radiologists.
- The streaming system had been piloted before being implemented and had been increased to a 24-hour system after it delivered evidence of reduced waiting times and breaches.
- The culture of the service was such that staff considered patients waiting in ambulances to be unsafe until they had been assessed and their condition diagnosed. As such the departmental norm was that the flow of patients from arriving ambulances into the department was rapid and smooth. A paramedic we spoke with said, “This is the best hospital in the area for not having to wait to handover patients. Even if staff can’t handover straight away, they give you eye contact and always listen.”

Nursing staffing

- The streaming nurse post had been increased from an initial daily duty period of 1000 – 2000 to 24-hours a day, seven-days per week to meet the demand for the service. The Royal College Of Nursing's (RCN) baseline emergency staffing tool (BEST) for nurse staffing levels was used to determine the rota. The trust was a member of the Shelford Group and as part of this, staff in the ED had modified and benchmarked their staff planning using the group’s acuity and dependency tool. During the day there were usually 18 staff nurses on shift and during the night this reduced slightly to 16 staff nurses. This met or exceeded the establishment of 17 staff nurses during the day and 16 night staff nurses. The resuscitation unit had three registered nurses at any time and the paediatric A & E always had a band six senior nurse as a supernumerary lead. .
- During our inspection we saw that the ED was very busy and that staff were deployed flexibly in relation to their skills and experience to ensure that the different areas of the ED were always staffed safely.
- A number of roles had been established in the ED to enable nursing staff to see people efficiently with a focus on assessment, care and treatment. This included reception staff who had been trained to watch the waiting area closely and speed up the treatment of anyone whose condition was worsening. The reception

desk in the major injury unit was staffed 24-hours a day, seven days a week to ensure that people were admitted and discharged in a timely manner. A supernumerary nurse flow coordinator was in post that was responsible for ensuring patients were admitted to the appropriate ward and who oversaw the escalation plan. This role was staffed by a senior nurse who was not in uniform and so could not be used for clinical treatment. This meant that the nurse was able to provide continuous, uninterrupted support to the clinical team.

- A team of 27 ENPs supported the ED, including six band six nurses and 21 band seven nurses. Some of this team were bank or agency nurses and they received the same induction and training as the permanent team, ensuring that the treatment and care delivered was consistent. 80% of the ENP team had been trained in minor illnesses, which meant that they had been able to expand their support role in the UCC.
- All permanent registered nurses in the paediatric ED were paediatric trained.
- Bank and agency nurses working in the ED had undergone a structured induction process. This included local policies and procedures such as the medicines management, infection control and drugs and IV administration policies. The chain of command in the trust and the escalation policy was included, as was the procedure to follow for patients in cardiac arrest. Paediatric agency nurses undertook an additional orientation to ensure they were aware of the layout of the department during the rebuild.
- A transferable skills policy was in place for bank, agency and travel nurses. This enabled senior staff to check the competence and training of temporary staff to make sure they were able to work safely in the ED. Evidence of prior training and learning was required of all temporary staff.

Medical staffing

- There were 86 WTE doctors in the ED, made up of 21% consultants, 56% registrars and 22% junior doctors. The ED met the College of Emergency Medicine (CEM) standard that consultant cover be provided for at least 16 hours per day.
- On night shifts, the physician in charge was a specialist registrar and was supported by two other middle grade doctors and three FY2 doctors. We saw from medical staffing rotas that the ED was meeting the requirement for 24-hour, seven day cover from an ST4-grade doctor.
- Each doctor was able to develop a specialist interest and conduct audits and research in this area, such as toxicology or sepsis. Consultants we spoke with told us that this was a positive element of working at St Thomas'.
- The resuscitation unit had consultant cover from 1000 – 1800 as well as a registrar and an FY2 grade doctor 24-hours per day. A second registrar was available in the unit from 1300 daily and a RAT doctor was available to be deployed to the unit 24-hours per day.
- The UCC was staffed by three GPs between the hours of 1100 – 2200. On Mondays and Tuesdays, a GP started at 0800 and there was always a GP available from 2200 – 0000. During busy times, a middle grade doctor was able to assist from the main ED. Overnight a see and treat doctor was available to reduce the impact of fewer GPs on site. When the UCC became very busy, doctors from the main ED could be redeployed to assist.
- There were three paediatric consultants and additional cover was provided by adult ED consultants with dual accreditation and two weekly sessions by a general paediatric consultant. Middle grade doctors worked in the unit from 0800 - 0000 Monday to Friday and 1000 - 2200 on weekends. Overnight, two middle grade paediatricians were on call from the Evelina London Children's Hospital, who also provided registrar cover to the children's ED. A minimum ST2 grade doctor was based in the unit overnight and additional support was provided by senior ED trainees. Middle grade doctors normally based in the nearby Evelina London Children's Hospital routinely covered shifts in the department and an on-call registrar from this location provided night-shift cover.

Major incident awareness and training

- Staff had undergone annual major incident training and were able to tell us the action they would take in such an event. The major incident policy was readily available in the ED and had been updated in June 2015.
- Nurses had undergone training in the triage and treatment of patients in chemical, biological, radiological and nuclear (CBRN) emergencies and environments delivered by specialist Metropolitan Police protection officers. Table top exercises had also been used to discuss scenarios and staff had received training in the treatment of VIPs in CBRN situations.

Urgent and emergency services

- Agency and bank nursing staff and locum doctors had been familiarised with the major incident plan during their induction. Two agency nurses we spoke with talked confidently about their role in a major incident and what the procedures were.
- Major incident equipment was stored and labelled appropriately and had been checked regularly. Action cards were available to assist staff during a major incident.
- A decontamination unit was available and all nurses had been trained in its use during simulation exercises. An isolation room suitable for patients with suspected Ebola infection was also maintained and kept ready for use 24-hours.
- A business continuity plan was in place for incidents in the city that could result in mass staff absence.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The ED had a comprehensive programme of local and national audits that contributed to improved patient outcomes. Staff were dedicated to improving practice following some audit results that indicated performance did not meet best practice requirements. We saw evidence of on-going progress and overall the efficacy of care and treatment represented an outstanding approach of research-active staff who were able to provide detailed evidence of their track record in improving service delivery and the subsequent impact on patients. Junior staff were encouraged to develop their capability in audits and this approach was embedded in staff training and development days.

Policies, procedures and protocols reflected best practice from the national guidelines of professional bodies included The Royal College of Nursing & Midwifery (RCN), the College of Emergency Medicine (CEM) and the National Institute for Health and Care Excellence (NICE).

The department had established strong, consistent and collaborative multi-disciplinary working relationships across multiple specialties, including dementia care, toxicology and mental health. Pathways that could be used by staff to refer people to community support organisations were integrated into the operation of the ED and substantially impacted the level of care available for the most vulnerable patients.

Evidence-based care and treatment

- A 2013 CEM audit of adult patients seen by consultants or a senior doctor for non-traumatic chest pain, febrile children less than one year old or patients making an unscheduled return with the same condition within 72 hours of discharge found that standards had improved since 2011 but were still worse than the England standard. In 2013, 6% of such patients were seen by a consultant, compared with 2% in 2011. Similarly, 42% of such patients in 2013 were seen by a senior doctor, compared with 33% in 2011.
- In a 2013/14 audit of severe sepsis and septic shock, the trust performed lower than the CEM key indicator requirements. The requirement that 50% of patients were administered antibiotics in the ED within one hour was not achieved as the department provided this in 26% of cases. The first intravenous crystalloid fluid bolus was given in the ED within one hour in 16% of cases, compared to the CEM standard of 75%.
- Sepsis audits from 2014/15 showed a significant improvement in consultant sign-off and patient outcomes. For instance, the London Cancer Alliance neutropenic sepsis audit for 2014/15 found that patient survival rates were very high, with one patient death attributed to sepsis. This audit also showed that patients in 2014/15 who presented with sepsis were consistently offered antibiotics within 50 minutes of arriving the ED.
- A 2015 audit of the consultant sign-off of patients with non-traumatic chest pain had improved from less than 40% in 2014 to 71%. This audit had been completed using CEM standards.
- Paediatric ED audits had been completed in safeguarding checks, pain management, asthma and fever in children under five years old.

Pain relief

- Patients had access to immediate pain relief if they arrived by foot, in the form of analgesia. They were also asked to identify the severity of pain on the initial registration form.

- Signs were on display in the main waiting area that encouraged patients to ask for pain relief if they needed it while they were waiting.
- The need for pain relief in the UCC was assessed by an ENP who was also able to take a urinalysis or blood samples.
- We asked three patients waiting in the initial assessment area if they had been asked about pain or offered pain relief when they had first spoken to a nurse. They all told us that staff had not asked about this.
- Patient records indicated that staff had documented a pain score for each person and this had been followed up appropriately. We saw that staff noted when analgesia had been offered and whether the patient had accepted or declined this.
- Where patients moved from the ED to the EMU, they were reassessed for pain.
- In all cases we found that patients in the paediatric ED had received a pain assessment and score.

Nutrition and hydration

- We saw that patients being assessed or treated were offered tea, coffee, water and sandwiches. A clinical nurse practitioner was also able to order more substantial food, such as hot soup, where necessary.
- We asked five patients who had been in the ED for two hours or more if they had been offered food and drink. Four people said that they had been offered something and one person said that they were hungry and thirsty and had not been offered anything.

Patient outcomes

- The department had a demonstrable track record in improving patient experience and outcomes because staff continually looked for improved pathways of assessment, diagnosis and treatment. For example, a deep vein thrombosis (DVT) pathway had been established during a DVT training programme. This focused on the risks of delaying treatment whilst waiting for blood results and helped staff to continue their investigations to improve the clinical outcome of the patient.
- During staff development days, an auditing tool was used to conduct a peer review of patient notes. This enabled staff to share best practice, learn from challenges and identify the most effective way of documenting care and treatment to improve patient outcomes.
- From January 2013 to February 2015, unplanned re-attendance rates to the ED had been below that of the England average for every month except May 2014, October 2014 and February 2015, when the rate was 9.5%. This meant that the department was performing better than expected with the national average. Staff we spoke with were aware of this and had begun to explore the causes of it and how they could reduce it. They demonstrated in-depth knowledge of the local population and said that many re-attendances were of homeless people who were not registered with a GP and did not have ready access to primary care services. Staff were supported by the Kings Health Partners Pathway Homeless Team (Pathway) could be contacted to try and alleviate re-attendances by referring homeless patients to hostels or other community outreach centres.
- The unit contributed to The Trauma Audit and Research Network audits, including the survival rate of patients discharged from the ED. From April 2013 to March 2015, the department performed better than expected with a survival rate of 98%. Additional research included the diagnosis of pulmonary embolism in pregnancy and a cardiology study for patients with atrial fibrillation. Staff were also feeding into a ballot for a 3D printer and were contributing evidence as to how this could impact patient outcomes such as those who needed an audible implant or valves.

Competent staff

- Staff of all functions, including administrators, nurses, doctors and consultants had received supervisions and appraisals at appropriate intervals. While on rotation, band five nurses had received six monthly appraisals from a mentor. Supervisions were given at the end of a two-week supernumerary period for new or trainee staff. Staff told us that their appraisals were focused on development and leadership. 100% of staff had received an appraisal in the 12 months to our visit.
- At the end of each shift, band six nurses were given up to 30 minutes to reflect on their work with the nurse in charge. The unit had ensured that staff remained competent by finding alternative sources of funding to support additional training, such as tropical disease training funded by the Florence Nightingale Fellowship.
- Band five, senior band six and band seven nurses had structured developmental pathways that included periods of mentorship and observation in clinical

competencies such as IV therapy and phlebotomy. The pathways were used to support staff in their development and to ensure they were competent before progressing to a higher grade.
- Senior nurses who were responsible for the streaming of patients at the initial reception desk had all undertaken a specialist ED training course.
- Two on-site PDNs and a third nurse who worked alongside Kings College London facilitated the training of staff in the department. Staff told us that the PDNs were a vital part of their development. One nurse said, "The PDNs are really, really good. They get you access to as much training as they can. We requested some extra training in palliative care so they arranged for a palliative consultant to come to one of our development days."
- ENPs had access to twice-yearly annual development days that included specialist sessions from the lead GP of the UCC, which enabled them to see patients with minor illnesses.
- Staff were allocated to a development day every six weeks, which protected their time for learning and training.
- Each Wednesday was designated as 'Teach Wednesday' for staff in the EMU. Teams were rotated to attend peer-teaching days at this time, during which individuals would disseminate their own learning and development of a specialist topic they had chosen. Staff we spoke with were unreservedly positive about this and told us that it made a significant positive contribution to their feelings of competence in the ED as well as their on-going development.
- Doctors we spoke with said that there were daily teaching opportunities during handovers and that clinical supervision meetings were focused on their development. All doctors in the ED had an educational supervisor.
- Doctors at or above senior house officer grade had been certified in advanced life support for adults and children.
- Consultants had attended a leadership course to enable them to deal effectively with complaints and incidents and to assist them in taking responsibility of different areas of the ED.
- GPs working in the UCC reported to a lead doctor who took responsibility for their induction and annual appraisals. Part of this process had included a project to improve the efficiency and skills of GPs working in this environment. This included the running of clinical governance groups with ENPs to discuss learning from peak times.
- Middle grade doctors normally based in the nearby Evelina London Children's Hospital routinely covered shifts in the department and an on-call registrar from this location provided night-shift cover.

Multidisciplinary workingA number of specialty teams were accessible by staff to provide liaison services, including the London Alcohol Recovery Centre. This was staffed by a qualified nurse and a healthcare assistant from Thursday to Sunday and was in place to provide care and treatment for intoxicated patients. During night shifts a registered mental health nurse (RMN) was always available on-call from a pool of nurses dedicated to this department.

- The ED was served by a toxicology lead who undertook regular audits and was leading a toxicology project to better treat patients presenting with conditions related to recreational drug use and alcoholism.Staff in the EMU used established protocols to decide how best to treat and refer their patients, such as referral pathways to cardiology and general medicine. Similar protocols were in place for patients about to be discharged that ensured onward follow-ups were arranged, such as to a GP or a rapid access chest pain clinic.
- ED staff worked well with paramedics who brought in patients, asking their opinion and taking part in a detailed handover. One paramedic told us, "Staff are always friendly, the meet and greet is really good."A play specialist was available in paediatric A&E and they covered various hours Monday to Friday with one weekend per month and one late evening each week. The play specialist had been involved in the induction of new nurses and doctors to demonstrate how they could reduce anxiety in children, such as through the use of effective distraction techniquesA British Red Cross hospital at home team was available for patients who could be managed at home without the need for a hospital visit. This team was on-call and could be engaged by ED staff.
- An ED consultant had been appointed who was dual accredited with intensive care (ITU). This had resulted in improved pathways for patients who needed to be admitted to the ITU service.
- A child and adolescent mental health service team were on site 24-hours seven-days a week. This team would

attend the paediatric ED to provide support to low-risk patients and could also assist with their transfer to the Evelina London Children's Hospital (which is within St Thomas' hospital).

- Handovers took place twice daily and were well attended by a multi-disciplinary team. They included a discussion of any breaches as well as the numbers of patients waiting in each area of the ED. In the handover we observed, new protocols were discussed and staff were advised that three new trauma mattresses had been delivered as well as an emergency lifting sheet to lift patients from the floor. The handover was detailed and helped staff coming on shift to plan ahead.The mental health liaison team worked under a service level agreement from South London and Maudsley NHS Foundation Trust. The team was based permanently at St Thomas' hospital and there were two PLNs dedicated to the ED. Out of hours, staff had office space in the ED to provide rapid support to the team when needed. The team worked closely with toxicologists to ensure that referrals to them were appropriate. For instance, the toxicologist would determine if a patient was exhibiting symptoms of intoxication rather than a psychotic problem before transferring their care.

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.
- Paper notes recorded using CAS cards were scanned into the electronic patient tracking system, which was checked by a weekly audit. This meant that patient notes were available for reference regardless of how they had been initially recorded.
- Staff had across to patient history notes in their records that would help 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. Staff had used this system effectively. For instance, a person who had repeatedly attended the ED requesting opiates was known to also attend another ED elsewhere for the same prescription. Staff had recorded this in their notes and were able to contact the other ED to ensure they were not prescribing excessive doses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were available for people with parental responsibility to consent on behalf of children.
- Staff we spoke with had demonstrable knowledge of the principles of consent and mental capacity, including the care and treatment of patients with a Deprivation of Liberty Safeguards order.
- We observed staff obtaining consent from patients before procedures or tests were undertaken, including the recording of verbal consent.
- Where staff had concerns about the use of the Mental Capacity Act (2005), a team of RMNs were available to attend the ED at short notice.

Are urgent and emergency services caring?

Good

Overall, the ED provided a caring and compassionate service that took into account the diversity and communication needs of patients.

We observed that most staff treated people with respect and compassion. Where this was not the case we found that senior staff had procedures in place to discuss attitude requirements with staff. Peoples' choices and preferences were respected and we saw that staff were acutely aware of the needs of patients based on age, gender, sexual identity and religious faith.

The ED had received numerous thank you cards and letters from patients, complimenting them on their treatment experience. Security staff in the department were highly praised for their compassionate approach to de-escalating situations of conflict.

Compassionate care

- We saw that most staff were naturally caring and demonstrated compassion towards patients. We observed a senior nurse welcome patients into the initial assessment area with a warm and welcoming

smile and a personal introduction. Nurses elsewhere in the department demonstrated similar levels of positive interaction. This was not demonstrated consistently by most staff although however. For instance, we observed a nurse who was streaming patients speak to people in an unfriendly, gruff manner. We also observed a registrar speak to a patient in psychological distress in an inflammatory manner, which resulted in the escalation of aggressive behaviour. We saw that such attitudes were rare and sSenior staff we spoke with showed us that a robust procedure was in place to improve the approach and attitude of staff where this fell below the department's standards.

- One patient told us that they were happy with the speed and efficiency of the initial assessment and streaming process but that the nurse who had seen them had not introduced themselves or explained their role. Another patient told us that the nurse conducting their initial assessment had answered a phone call while they were speaking. They said, "The nurse asked me what was wrong whilst he was speaking on the phone to the other person. He didn't smile or tell me what would happen next." A child in the paediatric A&E said, "They've been very nice to me here, I'm definitely not scared anymore." We witnessed numerous instances of caring and compassion from staff to patients and The same with the receptionist I saw afterwards. The others [receptionists] were apologising to people for the delay but mine didn't, he was unfriendly and just told me to take a seat."one person said, "The nurse I first saw was very good, 10 out of 10 for friendliness."Other patients we spoke with were more positive about their experience. one person said, "The nurse I first saw was very good, 10 out of 10 for friendliness."
- Compassion was very much a part of the daily operation of the ED. A noticeboard in a staff area was used to display photographs of missing persons, along with related information about health conditions that could make them vulnerable.
- The ED had received numerous letters and cards of thanks from patients for the care they had received. During our inspection, the department received a donation to their charity fund and a letter of thanks from a patient that thanked staff for their "…knowledge and experience which ensured I felt safe."
- Patients and visitors had contributed to the national Friends and Family Test (FFT), the results of which were slightly below the national average in the year to our inspection. For instance, in August and September 2015, an average of 85% of respondents said that they would recommended the department, compared with a national average of 87%. The majority of people who would recommend the ED said that they were 'extremely likely' to do so. Comments made in the FFT included, "Staff gave feedback in a clear, easy to understand way", "[Staff member] definitely knows how to approach little kids and occupy them without distressing them" and "I've not been left alone, I've been looked after every step of the way."
- Responses from the A & E survey indicated that in all response criteria the department performed at a level equivalent to or better than similar services. Patients reported clear information given to them regarding the need for tests and medications.

Understanding and involvement of patients and those close to them

- About 40% of attendees were from outside of the local area, with a significant number of international tourists. Staff demonstrated a good understanding of the needs and anxieties of people who needed to attend an ED when away from home on holiday. We observed a tourist who had injured himself arrive in the ED. The individual and presented with considerable anxiety about visiting an ED outside of his home country but e we saw that he was quickly welcomed and reassured by a member of staff who immediately built a rapport with and reassured him.
- Staff had been offered the opportunity to undertake a 'The Difference is You' course that trained them in recognising and responding appropriately to different personality types. This had helped to address complaints about staff attitude and the head of nursing told us that it had delivered positive results.
- Feedback from the Friends and Family Test included, "Feedback [was] given in a clear, easy-to-understand way" and "[Staff member] definitely knows how to approach little kids and occupy them without distressing them."
- Staff gave patients an overview of the process they would go through in the department rather than a timeframe for being admitted or discharged. This helped to alleviate anxiety that patients might have over the time they would spend there.

- We saw staff use appropriate methods of maintaining the privacy and dignity of patients. This included the use of curtains in treatment and assessment bays and holding confidential discussions away from waiting areas.

Emotional support

- Staff provided proactive and compassionate support and follow-ups to relatives after a person died. This included a telephone call the next day and a card sent six weeks later to express sympathy.
- We found an exemplary level of emotional support to patients who were particularly vulnerable or needed help other than medical treatment. This was facilitated in part through the teams' ability to use specialist pathways to refer patients to other teams and outreach workers. For instance, a patient who presented with symptoms of assault by their partner was moved to a secure area discreetly by staff and a domestic violence professional was contacted. The ED was later contacted by the person who said they had started a new life because of the caring actions of staff.

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

Outstanding ☆

The department demonstrated a consistently responsive approach to meeting the challenges of increasing demands for its services. This included the ability to manage rapid surges in activity and to plan ahead for major events. Pilot exercises were completed to establish the benefits of any planned changes in the operation of the department and staff were encouraged to contribute to related consultations. This was particularly apparent in relation to the flow of patients through the ED. Substantive evidence-based changes had been made to the staffing structure that had enabled the department to remain safe and effective during a major rebuild project.

Complaints and concerns were taken seriously and actively investigated and reviewed by dedicated staff using a transparent and robust investigation process. Where complaints had been upheld, staff had discussed the findings collaboratively with the complainant to discuss the learning that had taken place. Where a person was vulnerable or unwell, staff were able to adapt their approach to ensure they were included appropriately.

We found that the ED team was very much aware of the needs of the local population and had gone to great lengths to better understand how health outcomes could be improved their needs and explore how people could they could be better supported during their stay in the department and after they were admitted or discharged. This was driven by a focus on tailoring the service to address the needs of individuals regardless of their needs beyond immediate medical treatment, such as social care interventions. In particular, homeless patients and those who presented with symptoms related to the use of recreational drugs were well served by knowledgeable and understanding staff who demonstrated tangible determination to provide continuity of care that was fit for purpose and would reduce their reliance on the service in the future by encouraging engagement with community providers.

Innovative pathways of care had been developed through proactive engagement with other organisations that enabled the service to provide care for people with complex needs and who were vulnerable. .

While the department had not consistently met the 95% national target for four-hour treatment, robust streaming, triage and escalation policies were in place that we saw were used in the best interests of patients. The substantial rebuild of the department had impacted the target, which had been missed by between 0.5% and 2% during 17 weeks between January 2015 and September 2015, with some weeks indicating outstanding performance of seeing 97% of patients within four hours. Despite the pressures on the service from such performance targets, we found that staff maintained a proactive and exhaustive approach to better understanding their local population and exploring ways to plan and deliver services that addressed unmet needs. There was a commitment from staff to improve performance targets without compromising patient safety and there were areas of excellence within this, such as the department's significant track record of no black breachers from ambulance arrivals.

Service planning and delivery to meet the needs of local people

- The ED served a local population of homeless people and had established referral pathways that enabled staff to ensure patients received appropriate help once they had been discharged. This included a positive relationship with Pathway, the local authority crisis team, an alcohol team and a team of PLNs. The dedicated Pathway team had been engaged to address the high re-attendance rates of this population in the homeless population.
- We spoke with a patient who required support for access to social services due to homelessness. They told us that they had felt very welcomed by the nurse in the initial assessment area and that they felt safe in the department. Another person told us that a nurse had been able to refer them to the local authority crisis team very quickly.
- Senior staff in the ED worked closely with local authorities and event planners in London to ensure there was capacity available for an increase in patients during major events or celebrations, such as the London Marathon or New Year's Eve. This included an increase in staffing levels, a rolling escalation review process and the implementation of a single point of access to the department to ensure patients were streamed or triaged in the same place.
- The high prevalence of HIV in the local area had resulted in an initiative to offer HIV tests routinely to any patient who needed a blood test, which was offered according to NICE universal screening guidance. This was managed jointly between an ED consultant and a HIV consultant and was aimed at starting patients on anti-retroviral therapy as quickly as possible to improve their long-term prognosis. Immediate referral was provided to an HIV support team where a positive test resulted was received, which included a second confirmatory test. Over 25 patients previously undiagnosed had received a positive HIV test result since the start of the project, indicating a significant contribution to the reduction in the risks to patients associated with late diagnosis.
- Staff had a proactive approach to securing the assistance of external specialty teams to provide liaison services, such as the London Alcohol Recovery Centre. This was staffed by a qualified nurse and a healthcare assistant from Thursday to Sunday and was in place to provide care and treatment for intoxicated patients. During night shifts a registered mental health nurse (RMN) was always available on-call from a pool of nurses dedicated to this department. Domestic violence outreach workers and youth crime specialists were also available to the ED. Access to such specialist teams meant that staff could provide additional support above and beyond emergency medical treatment, which contributed to the reduction in re-attendance rates of patients with social care support needs.
- A play specialist was available in the paediatric ED and they covered various hours Monday to Friday with one weekend per month and one late evening each week. The play specialist had been involved in the induction of new nurses and doctors to demonstrate how they could reduce anxiety in children, such as through the use of effective distraction techniques.
- A quarterly 'frequent attenders' meeting was held with ED staff and the Pathway team. This was used to identify causes of frequent or repeat attendances that weren't clinically necessary and supported staff in redirecting patients to more appropriate services. Links had been established with other NHS trusts to help support people who tried to access multiple services to obtain opiates.
- The service manager and his team had worked to secure an ED-dedicated transport team that was available from 0900 – 2200 to support the non-emergency transfers of patients. There was also an out of hours contact line available to reduce unnecessary delays.
- A hospital at home team provided clinical care for patients who could be managed at home without the need for a hospital visit and were supported by a British Red Cross team. This team was on-call and could be engaged by ED staff.

Meeting people's individual needs

- A pathway was in place to help provide appropriate treatment and referrals for patients living with dementia. This included blue wristbands and stickers on notes to help staff around the hospital identify someone who may be lost or confused. Hospital passports were used by staff to help people who were transferred out of the ED into another department to be understood and a dementia link nurse was in post who facilitated this process. A consultant worked in toxicology as well as the department, undertook regular audits and was leading a toxicology project to better treat patients presenting with conditions related to recreational drug use and alcoholism.

- The ED was served by a toxicology lead who undertook regular audits and was leading a toxicology project to better treat patients presenting with conditions related to recreational drug use and alcoholism.
- Staff were able to request visits from domestic violence and homelessness teams. Such teams provided one-to-one support to people who needed assistance in accessing community services. The domestic violence team attended psychosocial meetings with mental health specialists when required.
- A clothing cupboard was kept in the ED that enabled staff to offer clean, fresh clothes to people. This helped to maintain the dignity of people who had damaged or unsuitable clothing.
- A liaison youth worker service was used by staff in the paediatric ED to refer patients who presented with violence or aggression or to follow up with young people who had been involved in gang violence. This service, named Oasis Youth Support at St Thomas' Hospital, was provided collaboratively by ED staff, the Guys and St Thomas' Charity, the Centre for Abuse and Trauma Studies at Middlesex University and Lambeth and Southwark Public Health. The project's work had been evaluated to assess the impact on patients and had demonstrated a significant increase in engagement with youth support workers and a parallel reduction in ED repeat admissions for violence-related injuries as a result.
- Management plans were in place for the care and treatment of patients with complex needs, including those in paediatrics. End of life care plans were also readily available.
- There was a clinical nurse specialist who acted as a link nurse for patients with learning disabilities. This individual had implemented services and resources for staff and patients that demonstrated a detailed understanding of people's individual needs. For instance, two communication boxes were available that included a magnifying glass, a hearing loop, hospital passports and communication cards. Electronic access to British Sign Language and Makaton was facilitated with the use of a laptop, which further demonstrated the drive in the department to ensure adjustments were made for patients with learning disabilities.
- Information for patients visiting the department was readily available and was up to date. Current waiting times were displayed on entry to the walk-in reception. An emergency floor project update was available to explain to patients why there were some areas closed off and what the immediate plans were for the next stage of the rebuild project. This included contact details for the managers leading the project.
- A printed leaflet was freely available in the waiting areas and initial assessment rooms that explained to people the reason for offering an HIV test if they also needed other blood tests. The procedure was explained clearly and the contact details of local HIV services provided by Terrence Higgins Trust and National Aids Map were also included.
- Information was also available in printed format for an independent domestic abuse advisory service and the British Red Cross support at home service.
- On arrival, large-print notices were displayed that explained to people that due to the use of a temporary reception, the initial registration area did not meet the ED's usual requirements for privacy and confidentiality. People were given the option to request a more private area for registration. Waiting times were displayed in at least two places.

Access and flow

- The streaming process ensured that serious illness or injury was identified early and helped to ensure that the service was efficient by sending patients to the most appropriate area immediately. Although patients could be referred to a local GP practice, there was no electronic record or tracking of this and the information was briefly noted in a diary. During busy times, there could be a queue at the initial assessment desk, particularly if a patient with a complicated condition or symptom arrived. During our observations we noted that staff working in this area had good levels of awareness of this problem and worked well together to reduce initial waiting times. For instance, we noticed that an escalation process was used when five patients were in a queue waiting to be seen, which included the redeployment of a nurse from the main ED to the streaming area to help with initial assessments.
- An initial assessment pilot had taken place from February 2015 to April 2015 and assessed the streaming process from multiple angles using the A&E standards and guidance of the CEM, the Emergency Nurse Consultant Association, the Faculty of Emergency Nursing and the RCN. The results of the pilot were used to set internal standards of assessment times and to reduce the number of breaches during peak times.

- Internal and external escalation plans, colour-coded for severity, were in place to respond rapidly to changes in demand on the service. For instance, a red internal escalation would result in clinicians working in offices being deployed into clinical areas to help. The emergency care pathway escalation protocol was robust and embedded into the daily operation of the department.,
- Nine pathways were in place to avoid unnecessary admissions where patients could be assisted by other teams, such as the homelessness team or the frailty team.
- The percentage of patients who left without being seen was higher than the England average in all months except one from January 20143 to JulyFebruary 2015. There was a protocol in place for staff to follow and a senior member of the team reviewed instances every 24-hours to identify any potential contributing factors. The focus on streaming patients effectively and ensuring that an initial assessment took place within ten minutes of arrival were used to try and reduce the number of people leaving without being seen.
- The trust had no Black Breaches between March 2014 and September 2015. Staff told us that their rapid streaming and triage processes ensured that patients arriving by ambulance were seen in the department quickly and that patients being kept in ambulances or in corridors was not tolerated. The culture of the service was such that staff considered patients waiting in ambulances to be unsafe until they had been assessed and their condition diagnosed. As such the departmental norm was that the flow of patients from arriving ambulances into the department was rapid and smooth. A paramedic we spoke with said, “This is the best hospital in the area for not having to wait to handover patients. Even if staff can’t handover straight away, they give you eye contact and always listen.”
- During the winter of 2013/14 and the winter of 2014/15, there were no ambulance delays over 60 minutes.
- From April 2014 to December 2014 the trust consistently met the national standard of a doctor seeing 95% of patients within four hours of their arrival. From JanuaryFebruary 2015 to September May 2015 the trust had not always met this standard but had, in all but one week case, performed at a rate above the England average. In all cases, 91% of patients were seen within four hours and the median performance was 93% during this period. The unique needs of the local population, an increasing demand for services and the reduced capacity caused by the department’s rebuild had contributed to the reduction of patients seen within four hours. Staff were able to tell us how they were mitigating the impact of this. In particular, a responsive streaming and triage process enabled them to direct patients to the most suitable part of the ED as well as to redirect local patients to a nearby GP surgery where appropriate. The inclusion of this on the department's risk register had led to staff creating a recovery and improvement plan that had resulted in an on-going assessment of the impact of the additional capacity in the acute assessment unit and weekly performance reviews.
- Daily meetings took place to discuss four hour breaches in the previous 24-hours, to identify causing factors and potential learning. We observed one of the meetings, in which staff identified 38 breaches from the previous 24-hour period. Staff identified that 19 of these had been caused by a long wait to see a doctor due to the volume of patients in the department and five breaches had been caused by the lack of medical beds available for patients who needed to be admitted. We saw that positive action was taken as a result of this meeting. For instance, patients who had been sent to the ED inappropriately from other services were given more information on the range of other services available to them locally.
- The total time spent in the ED per patient was higher than the England average in every month except two from January 2013 to March 2015.
- The number of patients waiting between four and 12 hours to be admitted to a hospital ward from the ED was better than the England average and below 5% in every month from April 2014 to April 2015. From 2012 – 2014, 2.94% of paediatric ED attendances breached the four hour standard. Most breaches were attributed to awaiting an admission to the Evelina London Children’s Hospital.
- The EMU provided additional capacity for 16 patients who received nurse and consultant care for up to 24 hours after they presented at the ED. An established pathway was in place that enabled staff to assess if admission to the EMU was appropriate. This included exclusion criteria such as cardiac arrest on admission or previous medical history that meant the patient could be treated more appropriately elsewhere.

- Every two hours a huddle took place between nurses, doctors and the service manager to discuss waiting times at initial assessment and the availability of beds in the EMU. This helped staff to plan patient flow and contributed to the nurse flow coordinator's role for the purposes of admitting, transferring or discharging patients in a timely fashion. The huddle was also used to discuss the need for an escalation if the department was full.
- Doctors from an adjacent acute medical admissions unit visited the ED when they had capacity to facilitate the rapid admission of patients. This helped to reduce the length of stay in ED.
- The unit had been nominated for a British Medical Journal award for its work on managing occupancy. Occupancy was monitored during two hourly huddles that were used to track occasions of overcrowding. We looked at 12 instances of overcrowding in the first week of September 2015 and saw that the emergency pathway escalation policy had been used effectively to reduce the impact of this. Excess occupancy during this period had typically been resolved within two hours, and in all cases within four hours.y

Learning from complaints and concerns

- There was a culture of openness around complaints in the department. The complaints policy was readily available in waiting areas and all of the staff we spoke with were able to confidently tell us what the procedure was if they received a complaint, including their responsibilities under the Duty of Candour.
- The complaints policy and procedure had been developed used established best practice guidance. For instance, NHS Litigation Authority guidance had been used to help staff to respond to complaints with empathy and to say sorry to people in the first instance. Guidance from the NMC had been used to help staff in ensuring learning took place after each complaint.
- Written complaints were investigated and responded to in detail and we saw that learning had taken place. For example, following a complaint from a person who had not received a necessary examination of their hand ligaments, the investigating nurse had produced a supplementary training leaflet so that staff could have a quick reference guide for this type of examination. The person who had complained was invited to the unit and was shown the training leaflet along with the opportunity to give feedback on how the complaint had been handled. Delays in identifying abnormal x-rays had been reduced from an average of seven missed occasions per year to zero in the year to our inspection. This was the result of an improved auditing process that had been implemented following a patient complaint.
- Key learning points from complaints were displayed on a dedicated notice board in a staff area. The most recent notice reminded staff to document the removal of cannulas before discharging patients and to discourage elderly patients from requesting they be discharged after midnight.

Are urgent and emergency services well-led?

Outstanding ☆

All of the staff that we spoke with told us that they were proud to work for the trust and in the ED. They told us enthusiastically and without prompting how much they valued the team working environment and how supportive their peers and senior staff were. Staff were aware of the trust's vision and strategy and were able to tell us what this meant for them and the department. A challenging and innovative strategy was in place to provide evidence-based, research-led care and treatment that encouraged staff to develop their professional competencies in an environment that was effectively led and benefited from proactive governance and performance management.

The ED had governance structures that were clearly understood and well-established into the leadership of the department. Collaboration between all levels of staff was described as "embedded and effective" by staff we spoke with and we saw that this culture empowered staff to feel part of the service and it's trajectory of improvement and development. Collaboration was also evident between staff in the ED and with other specialties in the trust, which led to a wide range of audit and research interests developing amongst the clinical team to deliver person-centred care.

We found that the department fostered a culture of research and development that was led by dedicated staff with a focus on improving the service and implementing innovative practices that addressed the specific needs of the local population and improved health outcomes for patients. Of particular note was the relationship with the

alcohol liaison team and Oasis Youth Support at St Thomas' Hospital team, which had demonstrably reduced negative outcomes for young people affected by or involved with violence in the community. Other staff-ledSuch research had led to improved streaming, faster ambulance handovers and the creation of a strategic role, a nursing lead for transformation.

Staff were rewarded for their work and this generated significant loyalty from all grades, including student nurses and trainee doctors who worked to return to the trust on completion of their training. Staff were readily accountable for delivering a high standard of care and treatment and the culture of 'no blame' enabled staff in all groups to strive for excellence and explore strategies of embedding better ways of working. Innovation, delivered safely, was encouraged, supported and celebrated by the senior team who facilitated flexible approaches to working for staff with interests in projects that would lead to sustainable patient care.

Vision and strategy for this service

- The 'Shaping our Future Together' strategy was embedded into the work of the ED and staff we spoke with were able to tell us how it applied to them and their work. Managers had access to a guide that helped them to facilitate discussions with different members of their team. The strategy was a reflexive process and staff were encouraged to contact directors to discuss it openly as well as to work together to build the local vision and strategy for the department. This included Senior leaders in the ED were focusing ed on responding to the needs of the local population, ensuring that the department was a 'great place to work' and increasing the research profile of staff.
- Staff were positive about the rebuild of the department and told us that they felt it was part of the long-term vision of the ED to ensure it was sustainable and able to meet the needs of the local population. It was very clear to us that staff at all levels of the department had a personal investment in the future of the service and that this was reflected in their positivity of their working environment. This was supported by the robust developmental pathways available for nurses seeking professional development and the frequent opportunities staff at all levels had to contribute to the running and development of the service.

Governance, risk management and quality measurement

- A robust clinical governance system was in place that was based on a tripartite structure and was led by the ED service manager, the clinical lead and the head of nursing. Our review of meeting agenda and minutes indicated that the governance system was used to monitor and improve the effectiveness of the department. For instance, a weekly multidisciplinary performance meeting took place that was used to discuss learning from incidents and complaints and also included morbidity and mortality discussions. The lead staff members for risk management, audits and governance attended a monthly committee meeting and we saw that the results of audits were discussed to drive improvements in practice. For example, the lead GP for the department's UCC had presented the results of a discharge letter audit that had resulted in staff education around the importance of spelling, grammar and meeting the six standards of discharge planning set out by the NHS Institute for Innovation and Improvement. Doctors had also presented the findings of audits such as head injury management and renal colic. In all cases we saw that the dissemination of information to clinical staff took place after governance meetings.
- Governance reports provided a detailed insight into the operation and challenges of the department, which were discussed by the doctors, nurses and managers we spoke with. There was a track record of involvement from multiple members of the team in governance meetings, particularly from a research-active nurse who had presented an updated policy on guidance for staff when patients did not wait to be seen or wanted to discharge themselves.
- Risk management was discussed as part of the two-hourly huddles that took place. The occupancy of the department was discussed and any breaches, staffing shortages or patient outliers were highlighted.
- There was a substantial drive in the department to improve the quality of the service through robust and consistent governance practices. A monthly clinical governance meeting was used to ensure that learning from incidents and complaints was embedded into the

practice of the ED. As a result of previous difficulties in transfer processes, a transfer project had been implemented to identify best practice guidelines for the transfer of patients.

- Senior staff we spoke with told us that maintaining staff morale during a period of increasing demand as well as keeping staff safe were areas of concern for them in the near future.
- The service engaged with the Urgent Care Network and was supported by the Clinical Commissioning Group. This relationship had resulted in the funding of a nurse-led discharge pathway and improved access to out of hours GPs.
- We saw that the risk management procedure included the use of a risk register to track controls and actions used to reduce risks. There was a track record of exploring better working practices and implementing systems to reduce the impact of risks on patients, staff and the service. For instance, to prevent patients with complex needs being discharged inappropriately, consultant cover in all areas of the ED had been increased and a more robust handover procedure had been implemented using a daily protected time slot. Six full time ED consultants had been recruited to provide seven-day cover extended to midnight to improve the response rate for specialty assessments. Staff training had been improved in personal protective equipment and the management of challenging patients and pharmacist-led teaching had been implemented to address associated risks. All items on the risk register had been assigned to a named manager and in all cases an action update had been provided at least quarterly, and in most cases more frequently. Where a risk had been 'closed' on the register, evidence had been provided as to the outcome of a change of practice or policy, such as the introduction of a business continuity plan to address the risk of mass staff sickness.
- The overall approach to risk management included the views of clinical staff in the ED. In June 2015 a staff survey had taken place to find out what nurses and doctors perceived to be the main risks to their patients, their work and the organisation as a whole. The most common risk highlighted by staff was violence and aggression from patients. This risk was included on the risk register and following the survey, improved training had been provided on patient management with input from the security team and silent alarms had been issued to all staff. A weekly security meeting also took place, which was used to address staff concerns.

Leadership of service

- All of the staff we spoke with told us that they were very happy with the management and leadership of the unit. There were clear lines of accountability in place and staff were aware of who they could go to for help or to escalate a problem. Staff told us that the matron and senior nurses were all very approachable and had an 'open door' policy if they needed any extra support.
- Staff told us that the increasing demands on the service was their biggest concern and they felt that senior managers understood this and were working to mitigate the impact on staff performance and morale. One member of staff told us that the leadership team had undertaken a staff modelling project to look at where the greatest needs were in the department in terms of staff deployment and skill mix. Staff in the department we spoke with told us that they had confidence in the leadership team and that they felt morale was consistently well maintained.
- Junior doctors we spoke with told us that they were happy with the support they received from consultants and that they felt their rota was satisfactory and manageable.
- Doctors told us that they received support from the executive team when they implemented an escalation plan during times of surging demand.
- Managers were keen to reward staff for their perseverance and flexibility during the department rebuild and had done so by organising a tea party at the end of each major stage.
- A staff survey had asked people to identify three good things that had happened to them on their shift. The most popular responses were teamwork and communication between staff.

Culture within the service

- All of the staff we spoke with talked openly about the supportive and motivational culture of the service. They told us that this helped them to develop their skills and that they appreciated the opportunity to learn from mistakes and gain experience in a department that demands high levels of competence.

- The culture of the service encouraged staff to be loyal to the department and trust and to drive forward improvements in the service. For instance, three consultants told us that they had completed part of their junior training in St Thomas' ED and had worked to return to the department on completion of this. A senior nurse said, "This is a good trust to work for. It comes from the chief nurse and we're all very patient-focused. There's no 'us and them' attitude between doctors and nurses – it's very much a team environment."
- Each month a survey asked staff to name three 'good things' about their shift and the results were displayed for their colleagues to read. We saw that the most common response at the time of our inspection was 'good team work and communication', which 21% of staff had identified as the most positive thing about their shift.
- We saw that an 'Inspirational Educator of the Year' award had been dedicated to the memory of a previous member of staff was used to reward dedication and progression in training.

Public and staff engagement

- Staff demonstrated engagement and transparent communication with the public in relation to the rebuild of the department. This included a detailed visual timeline on display demonstrating to visitors the progress being made and key achievements. Detailed information was also provided in printed form for people to take away that detailed the work completed to date and what they could expect from the next stages of development. A point of contact was also provided so that patients and visitors could speak directly with a project manager if they wanted more information or to give feedback.
- Part of the culture of communication and engagement included inviting people to meet clinical staff following a complaint or incident investigation. From looking at the minutes of such meetings and speaking with staff, we saw that appropriate clinical and management staff had facilitated the meetings and that people's views and insight had been encouraged and listened to. On arrival, large-print notices were displayed that explained to people that due to the use of a temporary reception, the initial registration area did not meet the ED's usual requirements for privacy and confidentiality. People were given the option to request a more private area for registration.
- A designated member of staff in the department was assigned to monitoring patient feedback on the NHS Choices website. Where positive feedback was received, this was passed on to staff and where areas for improvement were indicated, this was added to the agenda of clinical governance meetings.
- Staff had been actively involved in the rebuild planning of the department and had been asked what they found most challenging about the original design that could be used to improve working practices in the new design.
- The leadership team recognised the need to engage with student nurses and had an active placement programme with two local universities. Student nurses were given a full induction and a dedicated nurse acted as a student placement officer. There was a focus on nurturing future talent and student nurses were encouraged to work actively with permanent staff to develop themselves.

Innovation, improvement and sustainability

- Senior nurses had a very positive and proactive approach to developing their teams clinically. For instance, the band six ENP role had been introduced as a developmental route. Following a specialist one-week training course in the ED, nurses progressed to an academic course at Kings College London. This had resulted in a number of promotions to band seven ENP posts. As a result, junior nurses viewed the ENP role as a career progression route to build their expertise and skills. This focus on staff development was supported by the PDNs and as such staff had a wide range of training and development opportunities from which to progress. Junior nurses we spoke with said that they felt loyal to the service and confident in their professional future because of the embedded culture of skill and service improvement.
- A risk to service sustainability had been identified if nurses failed to achieve the new Nursing and Midwifery Council 2016 revalidation requirement. In response senior staff in had formed a revalidation Board to oversee the process and to begin communicating with nurses six months before their revalidation was due to help them to prepare. A programme of workshops had also been developed to help nursing staff to prepare.
- The use of development pathways to support staff in gaining skills was a strategy to ensure the service was sustainable in terms of safety and responsiveness and demand increased. In addition to the development

opportunities for band six ENPs, healthcare assistants had been given additional training that enabled them to complete health observations and take blood samples from patients.

- Staff had been encouraged to take part in the consultation process during the design of the rebuild project, particularly in relation to how they planned to provide a safe and efficient service for increasing numbers of patients. Staff had worked with architects from the Design Council to plan cubicles and units that would reduce the risk of violent or aggressive behaviour from patients with mental health needs. Staff told us that this had been a very positive experience and that they had felt the designers were dedicated to creating the 'ideal cubicle' for them.
- Security staff provided an innovative and effective support service to ED staff and were very highly respected. The security team was able to respond rapidly to emergencies and in a way that was intended to reduce anxiety and tension in patients. Both male and female officers were available and individuals in the team spoke several languages, which nurses told us had been crucial in assisting them during tense or challenging situations. Security staff had delivered conflict management training to ED nurses and we saw that this was used to a positive effect in the department. Staff from the mental health liaison team told us that security staff played an important role in the department. One person said, "Security are incredible. They regularly take my breath away with their level of skill and compassion at de-escalating situations with psychiatric patients. They build a rapport very quickly and show an astounding level of skill."
- The focus on learning and development of staff was entrenched in the operation of the ED. Each morning during the multidisciplinary handover, a clinician would present a 'slide of the day' as a clinical case presentation. We saw that the whole team discussed this and facilitated on-going peer supported learning.
- The department demonstrated considerable foresight in its approach to engaging with staff who wanted to develop research and practice-based innovation. A senior nurse had undertaken an MSc Research in Clinical Practice and had been designated the nursing lead for transformation, with a remit to lead on innovation in the department. This individual had led five distinct projects aimed at delivering a range of service improvements. These had included the clear separation of clinical and management nurses to better handle capacity and flow as well as structured learning from other A&E departments to reduce ambulance turnaround times. This research had led to the implementation of 24-hour reception staff in majors as well as the implementation of nurse-led investigations in adherence with NICE guidelines. The nursing lead for transformation had visited other A&E departments with advanced nurse practitioners (ANPs) who were able to treat patients who were critically ill and support them from their first arrival at the ED to their ultimate discharge. Using ANP competencies from the RCN and CEM, trust support had been secured to develop this role and prepare a job description to begin future recruitment.

Medical care (including older people's care)

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

Information about the service

St Thomas' Hospital is an acute hospital with 302 beds providing a range of medical care services. These include cardiology, gastroenterology, respiratory medicine, general medicine, stroke and geriatric medicine.

In the period April 2014 to March 2015 St Thomas' admitted 26,779 patients to the hospital. Of these 30% were general medical patients and 16% were admitted to cardiology.

We inspected the admissions ward, general wards (Hillyers, William Gull, Albert), care of the elderly wards (Henry, Anne) and cardiology wards (Coronary Care Unit, Stephen).

We spoke with 33 patients including their family members and carers, 64 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients and staff, considered the environment and looked at 14 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

Overall we found medical care services at St Thomas' were good.

The safety of medical care services was good. There was a positive culture of incident reporting; staff understood and fulfilled their responsibilities to raise concerns and report incidents. We found measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were consistently high and regularly audited. We found there were sufficient doctors and registered nurses on duty; staffing levels were tracked four times a day across the hospital. Patients who were deteriorating received a speedy response and had their care reassessed.

We rated the effectiveness of medical care services as good. Staff were well supported with access to training, clinical supervision and development. Use of NICE guidance was used across a range of conditions. There was a programme of national and local audits regarding clinical practice in place. Patients were assessed by a dietician when screening suggested a risk of malnutrition.Patients' nutritional needs were assessed with scores recorded and risks identified. Consultants covering acute medicine 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.

Medical care (including older people's care)

We rated the caring aspects of medical care services as 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. Patients told us they were involved in decisions about their care and treatment and were given the right amount of information. The trust's performance in the Family and Friends test (FFT) was consistently higher had a higher than average response rate to the Friends and Family test (FFT) than the England average.

We rated the responsive aspects of medical services as outstanding. The admissions ward was overseen by multidisciplinary medical teams who undertook assessments and provided a rapid response to reduce unavoidable admission and improve early discharge. The hospital proactively managed patients discharge. Where a patient's discharge was delayed this was escalated to the discharge team to progress.
Most patients 79%, (21,405) 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.

We rated the well-led aspects of medical services as good. Staff were aware of the trust and acute medicine vision and incorporated this as part of their daily work. The culture within the division was one of openness and honesty. There was an appropriate system of clinical governance in medical services that identified quality and risk issues. Staff reported they were supported by their managers and department heads. We found staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

Are medical care services safe?

Good

The safety of medical care services were 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 wards scored between 93% and 100%.

We found 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 to provide advice and guidance when required. Mandatory training helped ensure staff had current knowledge and skills in key safety areas. However, compliance with mandatory training overall for the medical division was 81% for medical staff and 90% for nursing staff which was below 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 staffing levels or skills mix were not as planned. Staff would be moved to different wards within acute medicine to ensure safe staffing would be maintained or bank and agency staff would be utilised.

Patients who were deteriorating received a speedy 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. Staff were aware of when they had escalate to the medical team and the site advanced nurse practitioner (ANP). The ANP would undertake a full assessment of the patient and commence treatment.

Medical care (including older people's care)

Incidents

- The service reported one never event which was classified as a medicines drug incident in August 2014. We saw the incident had been investigated and a root cause analysis (RCA) had been undertaken and lesson learnt and good practice had been identified. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Medical services at St Thomas' reported 50 serious incidents out of 140 reported by the trust between May 2014 and April 2015. This represented 36% of all incidents in medicine. The most common incidents reported were pressure ulcers (33) grade three and four and slips, trips and falls (10).
- 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 a software system and feedback was given. Learning from incidents was also highlighted in ward staff newsletters and ward communication diaries. On Hillyers ward staff also completed a 'reflection' post incident which gave staff an opportunity to debrief and reassess. Learning from incidents was also displayed on the safety board with the wards top three incidents displayed.
- Acute medicine Morbidity and Mortality meetings were held regularly. We saw minutes of the meetings which showed medical care services were involved in these meetings and the management of medical patients was scrutinised and that action points and lessons learnt were identified.

Duty of candour

- Duty of Candour was considered as part of the investigation and RCA into serious incidents. We saw that the involvement and support of patients and relatives was documented detailing the actions taken.
- 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 was a guide for patients, families and carers and gave details of sources of further support available.

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 C.UTIs reported via the patient safety thermometer were varied and showed no noticeable trends.
- Safety thermometer scores for 'harm free' care for August 2015 showed that the medical wards scored between 93% and 96% with Mark ward was scoring 100%.

Cleanliness, infection control and hygiene

- Cleaning audits of the acute medical wards were undertaken monthly. We looked at cleaning audits for the period May 2015 to September 2015. The cleaning audits 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 in the period achieved 95% all more for cleanliness with Stephen achieving 93.90% in August and Becket 93% in September.
- 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. On Mark ward we saw the night staff cleaning checks were on display which indicated that the commodes had been cleaned and equipment checked. We saw that green 'I am clean' labels were in use to indicate equipment had been cleaned within the last 24 hours. One of the ward managers reported that staff were encouraged to clean equipment after use.
- The service had no reported incidents of Meticillin-resistant staphylococcus aureus (MRSA) and 21 incidents of Clostridium Ddifficile (C Diff) between April 2014 and June 2015. We saw that where incidents of C Diff had occurred these had been followed up in the clinical governance meetings.

- Adequate hand washing facilities and hand gel were available for use at the entrance to the wards/clinical areas and 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 staff generally washed their hands in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene." We saw that there were monthly infection control audits; these included an audit of hand hygiene which showed for the period April 2015 to July 2015 that acute medicine achieved 90% or more compliance.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted that all staff adhered to the "bare below the elbows" guidance in the clinical areas.
- 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.
- We saw that clinical and domestic waste was appropriately segregated and that there were arrangements for the separation and handling of high risk used linen. We observed that staff complied with these arrangements.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they 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 and Prevention Control 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 acute medicine service 77% of medical staff, 82% of nursing staff and 50% of allied health professionals had completed the training.

Environment and equipment

- The trust score was above the England average in 2013 and 2014 for Patient Led Assessments of the Care Environment (PLACE) in the sections of cleanliness and facilities.
- We observed that ward corridors were generally kept clear of equipment therefore avoiding trip hazards so people were kept safe. On Henry ward we saw hourly ward checks were carried out. Some wards presented challenges by nature of their layout for example the coronary care unit (CCU) shared its sluice and kitchen with another ward and was located on a different floor to the other cardiac wards. and.
- 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 and we found that the checks had been completed with no omissions in the records.
- We saw all Electrical Medical Equipment (EME) had a registration label affixed and that it was 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 were safe to use.
- Health and safety and fire safety training was part of the statutory training programme which staff were required to attend. The trust's target was 95% of staff having completed the training. Within the acute medicines services 94% of medical staff, 99% of nursing staff and 100% of allied health professionals had attended training for health and safety and 77% of medical staff, 82% of nursing staff and 50% 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. 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 acute medicine wards and worked across the wards seven days per week so pharmacists ensured that the wards maintained their stock level.
- 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 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.
- We saw that medicines were stored in dedicated medicines fridges when needed; these were locked and the fridge temperature was recorded and were within the acceptable range . Stock medicines were stored securely in the treatment room on the wards.
- Patient's own medicines were stored securely in lockers next to the patient's bed, staff had a key code which enabled them to access the patient medicines when administering. We observed medicines rounds in progress and saw staff check 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

- The acute medical services were in the process of rolling out electronic patient records across the wards. The integrated electronic patient records 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 for example 'This is me' documentation, fluid charts and the patients care plans. As the system was still being introduced on the wards, we observed that there were prompts for staff to remind them where they would find different records. Staff told us that they were able to access 24 hour IT support.
- On the acute admission ward we found medical staff had to type up patient notes into the electronic record who had been transferred from the accident and emergency service as the department used hard copy notes.
- On the wards we saw high visibility of computers on trolleys and on occasions up to five members of medical, health care and nursing staff all with computers trolleys around a patients bed on a ward round. Ward managers were aware and were considering how this could be reduced.
- Medical records were stored securely, staff could only access patient electronic records using a log on and paper records were stored securely in lockable units either on or next to the bays.
- We looked at 14 sets of patient records and found that patient notes were fully completed. Risk assessments had been completed on admission and reviewed daily and these included pressure ulcer risk assessments within 6 hours of admission, Venous Thromboembolism (VTE), nutritional and falls risk assessments. We saw that where patients had been identified as a falls risk they were issued with red non slip socks and had wrist bands so staff could identify patients at risk of falling when they left their bays.
- Wards had appropriate arrangements for the disposal of confidential waste.
- Information Governance was part of the mandatory training programme which all staff were required to attend. The trust's target was 95% of staff having completed the training; within the acute medicines services 66% of medical staff, 75% of nursing staff and 100% of allied health professionals had attended training.

Safeguarding

- Staff had access to the trust's safeguarding policy and knew how to access the safeguarding team for 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 and 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 and 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 given examples of concerns they had identified and referrals made. Staff told us that 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 acute medicines services 90% of medical staff, 98% of nursing staff and 100% of allied health professionals had attended safeguarding vulnerable adults 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 protection 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 the acute medicine service was 81% for medical staff, 90% for nursing staff and 92% for allied health professionals. This was lower than the trust target of 95%.

Assessing and responding to patient risk

- Patients clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National for Health and Care Excellence (NICE) guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system based upon these observations 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 logins to access patient records to ensure professional accountability. Temporary staff were also allocated logins. This meant 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 that staff were using the NEWS scores appropriately. Staff told us that 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 a fluid balance chart started if not in place, and the medical team and the site advanced nurse practitioner (ANP) would be called. The ANP would undertake a full assessment of the patient, commenced treatment and decided when the patient needs to be reviewed and by whom. An ANP told us "We they want to know the minute a patient starts to become unwell".
- AMBER care bundles were in use on acute medicine wards for patients who were deteriorating or patients where there 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 and putting plans in place should the worst happen.
- 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 where appropriate care plans had been formulated. Risks were communicated to staff using symbols for example patients who were at risk of falls had a red sign on the end of their bed and wore red non-slip bed socks. This meant patients who were at a risk of falls were quickly identifiable.

- Records showed that patients had been seen on a post take ward round within 12 hours of admission which is in line with best practice guidance. Diagnosis and management plans were in place, nursing assessments had been completed and care plans were in place.
- Adult basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 95% of nursing staff having completed the training; within the acute medicines services 90% of nursing staff had attended training.

Nursing staffing

- Vacancy levels for qualified nurses across acute medicine division at St Thomas' was 17% (about 50 Wwhole time equivalent WTE) and the trust were waiting to fill the posts with newly qualified staff. The service had increased qualified nursing levels on the wards at night in line with The National Institute of Health and Care Excellence (NICE) guidance. 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. These new staff members were awaiting start dates between nthe time of our inspection and January 2016.
- 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 actual staffing levels were generally in line with planned staffing levels. Depending on the ward, nurses were attached to bays or allocated to patients. Staffing levels were determined by using an acuity tool to determine safe staffing levels. Wards were staffed with a 1:6 nurse to patient ratio and ward sister were supernumerary to the agreed staffing levels so they could support ward staff if patient acuity or occupancy increased. Staff who provided one to one support for patients (specials) were not counted in the staffing level.Band 2 and 3 staff were specifically trained as 'specials'. We saw the specials were utilised across the wards overnight and during the day. The number of specials were reviewed daily and patients' needs assessed for that the wards could safely manage the risk. The specials had been trained in distraction techniques.
- Staffing levels were tracked at four points during the day as part of the situation report meetings. Ward managers reported if their wards were safe or 'red flag' if staff levels or skills mix were not as planned. Ward managers reported staff would be moved to different wards within acute medicine to ensure safe staffing levels were maintained and bank or agency staff would be utilised if needed.
- We observed five handovers from night to day staff and found them to be appropriate and robust. Staff had printed hand over notes which they updated during the handover. All the patients were discussed, NEWS scores were highlighted, and patients who needed to be visible to staff were identified. Actions outstanding for patients due for discharge were allocated. On one ward, the hand over was done outside the patients bay and the nurses coming on shift introduced themselves to the patients.
- We saw that where wards used temporary staff, staff were inducted on to the ward and a induction check list was completed and signed. On one ward we observed the ward manager check the credentials of an agency staff member who had not worked on the ward before and provide them with an appropriate uniform.

Medical staffing

- Consultants represented 36% medical workforce in line with England average of 34%. Middle career doctors represented 5% in line with an England average of 6%; Registrars represented 45% which is better than the England average of 39%. Junior doctors represented 13% which is worst than the England average of 22%. This means there were fewer junior grade doctors than the England average whilst the proportion of registrars exceeds that of England.
- The average locum rate for acute medicine from April 2015 to May 2015 was 5.6%. This equated to 13.37 WTE consultant/ doctor posts in acute medicine.
- At night the acute medicine directorate at St Thomas' covered their own wards and the acute admission ward. The night medical cover consisted of two registrars, and two junior doctors covering the wards and admitting patients. take. Medical staff told us there was "a proper hospital at night team" and that they were able to contact the on call consultant. The on call rota was covered from within the current workforce. Consultants would also phone in during the evening to support medial staff.
- At night the medical staff had regular "huddles" to discuss patients and work load across acute medicine.

Medical care (including older people's care)

- Medical staff reported their workloads were manageable and there were sufficient doctors on call during the day and at night.
- We observed three medical hand overs and found them appropriate and robust. Medical handovers were twice daily in the morning and evening. On the admission unit the hand over was consultant led; all the patients and treatment plans were discussed with the medical staff coming on shift.

Major incident awareness and training

- The hospital had a site control room which operated 24 hours per day 7 days per week which provided a single point of coordination. The trust's business continuity plan set out the level of escalation and response required.
- Staff we spoke to were aware there was a procedure for managing major incidents or an event that impacted on business continuity. On wards we saw there was a major incident folder. Staff we spoke with advised that they would await instruction from their ward manager or the lead site nurse practitioner (SNP) who was based in the site control room.

Are medical care services effective?

Good

We rated the effectiveness of medical care services as good.

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.

Use of National Institute of Health and Care Excellence (NICE) guidance was in place across a range of conditions. There was a programme of national and local audits regarding clinical practice in place. Good outcomes were achieved for patients with strokes and an A rating in the Sentinel Stroke National Audit Programme (SSNAP) was given for stroke services between October and December 2014.

Patients were assessed by a dietician when screening suggested a risk of malnutrition. Patients' nutritional needs were assessed with scores recorded and risks identified. Nutrition boards had full details of patient's nutritional needs and preference. We observed 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 acute medicine were available seven days per week. Wards and specialist medical teams had access to a full range of allied health professional 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 that consent forms to treatment forms had been signed by patients prior to medical procedures. We spoke with staff about the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS). Staff understood the basic principles of the Act 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.
- Staff understood the NICE guidelines and stated that these were referred to in discussions with staff about patients' care and treatment
- Staff reported that clinical policies and guidance were available on the trust intranet. We reviewed policy guidance and policies and judged they were compliant with current guidance and best practice. We noted all local guidance that we reviewed carried a review date.
- The acute admission ward operated an ambulatory care model. The aim was to review patients within 4 hours from attendance at the ED. This meant that patients who did not require admission or could be seen as an outpatient could be managed there. The acute medicine service reported 60% of patients were discharged within four hours.
- In acute medicine an audit of patient observations were undertaken on the wards in October 2014. The audit showed that of the 1376 patient observations undertaken that 99% of observations had been fully completed.

Medical care (including older people's care)

Pain relief

- Patients told us that they had received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate actions to ensure 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 "intentional rounding" processes (where staff attend patients at set intervals to check a range of patient-centred issues) staff ensured that patients were comfortable and recorded this in patient records
- The palliative care team also provided support and advice in the pain control of those who were terminally ill.

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 foods. 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 three wards; we found they were well organised even though there was a variety of food being 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 with eating were served first, followed by patients who needed to be observed or assistance with their food. This ensured all the patients had hot food 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 green or blue trays for patients 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 by nursing staff 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 fluid thickeners were used as planned. We were advised that nurses performed swallow assessments and patients had 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.
- We observed that 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 patient fluid intake.
- Patients we spoke with were generally satisfied with the quality and range and choice of food that was offered. Food that met people's cultural and religious needs was available, such as halal food. A patient who was on a halal diet told us "the food was very tasty".
- We saw there were adequate arrangements to ensure food safety. For example we found that 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 safe temperatures.

Patient outcomes

- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP) which is an on going national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At St Thomas' the stroke services scored A in October to December 2014 and A in January to March 2015. With 70% of trusts achieving a D rating, this indicated the hospital was achieving good outcomes for patients with strokes in line with the national average.
- The hospital participated in the 2012/2013 National Heart Failure Audit and scored above the England average in all seven standards audited for clinical

practice for in-hospital care. The hospital also scored above average for clinical practice for patients being discharged from hospital in five of the seven standards audited.

- The hospital participated in the Myocardial Ischemia National Audit Project (MINAP) which is a national clinical audit of the management of heart attack. In 2012/13 and 2013/2014 the hospitals scored better thanabove the England average in all three standards audited.
- In the National Diabetes Inpatient Audit (NaDIA) September 2013 the trust's performance was monitored against 22 indicators, in 14 of the indicators the trust performed better than other trusts and in seven indicators the trust was worse than other trusts.
- Across medicine the average length of stay was 8.2 days which was worse than the England average of 6.8. In general and care of the elderly medicine which represents the majority of the activity, the average length of stay was worse than the England average. In general medicine it was 7.7 days compared to the national average of 6.4 days and or care of the elderly medicine it was 17 days compared to 10.1 days which was the England average.
- Between December 2013 and November 2014 the standardised risk of re-admission for acute medicine and the medical specialities was slightly above the England average for both elective and non-elective admissions. Elective cardiology, gastroenterology and respiratory medicine and non-elective general medicine, cardiology and clinical haematology all had a higher than average risk of readmission.

Competent staff

- All new staff were inducted into 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. We found documentation in ward areas and medical speciality units, together with reports on the central records system that identified current appraisal rates. The trust reported 73% 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 trust's target of 95%. Staff reported that the appraisal process was a positive experience with objectives and targets set, they felt supported by their managers and colleagues and that there were opportunities for development and training. Staff either had an appraisal or knew when their appraisal was due.
- New nursing staff were able to rotate across different specialities within 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 link functions for example became responsible for the alcohol liaison and led on alcohol related initiatives to develop colleague's skills and knowledge. Practice development nurses and advance nurse practitioner's also worked across the wards to support staff and develop their skills.
- Throughout our inspection we observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- We saw there was a wide range of specialist nurses, for example the dementia and delirium team, palliative care team, diabetes nurses, safeguarding and dementia leads, who supported staff in ensuring they were delivering competent care. We noted their presence on the wards and staff told us they valued the input of these teams who were proactive at team meetings and on the wards.
- 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 is a video regarding care of a patient living with dementia.
- 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 that they were able to gain experience of working in different hospitals. The junior doctors felt workloads were manageable and they felt valued.
- Nursing staff reported that there were workshops for training staff on how to comply with Nursing and Midwifery Council (NMC) revalidation requirements.
- Consultants reported there were systems in operation regarding revalidation of GMC registration.

Multidisciplinary working

Medical care (including older people's care)

- We saw that multi-disciplinary working was evident on medical wards; physiotherapists and occupational therapists were part of ward board rounds on a daily basis. There was also evidence of a multi-disciplinary approach to discharge planning.
- Ward and specialist medical teams 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 they had recorded this in the electronic patient records. Social workers were also based on the geriatric wards to facilitate social care packages for patients on discharge.
- Medical and nursing staff of all grades that we spoke with all described excellent working relationships between healthcare professionals. We observed the healthcare team worked well together to provide care to patients. For example we observed an allied health professional working with a nurse to mobilise a patient and suggestions were given to the nursing staff on what they could do to assist the patient when the physiotherapist was not on the ward.
- 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

- Consultants covering acute medicine were available seven days per week as consultants led daily ward rounds. Ward staff reported that doctors who were ward based Mondays to Fridays and at weekends they were available via a bleep if required.
- Staff reported that 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 patients were able to obtain their discharge medication.
- Physiotherapy and occupational therapy staff and dieticians were available at weekends on the acute medicine and stroke wards.
- Speech and language therapists (SALT) provided five day a week service; nursing staff had been trained to undertake basic assessments.

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 were 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 that 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 that consent forms to treatment forms had been signed by the patients prior to medical procedures. Paper copies were retained in the patient's 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 2005 (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 assessment. All DoLS applications were also dealt with by the safeguarding team.
- On wards we saw where patients had DoLS in place that they had "specials"(staff who provided one to one support) that monitored them.

Medical care (including older people's care)

Are medical care services caring?

Good

We rated the caring aspects of medical care services were 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. Treatment was provided in a respectful and dignified manner. 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 wards we visited we saw that they had their FFT results for August on display and saw that the majority were over 95%.

Compassionate care

- The trust used the Friends and Family test (FFT) to get patients' views on whether they would recommend the service to family and friends. The FFT scores during the period March 2014 to February 2015 had an average response rate for individual wards which ranged from 26% to 48%. Overall, these showed satisfaction with the service with the medical wards scoring from 82% to 100% during the period. On wards we visited we saw that they had their FFT results for August on display and saw that the majority were over 95%.
- We observed interactions between nursing staff and patients were professional, kind and friendly. For example we observed a patient kiss a doctor on the forehead; the doctor had given the patient time to discuss their needs. Several patients told us that they thought the nursing staff were good and caring. Some of the positive comments we received from patients were; "Staff know you as a person not just another one in a tick box", "Care is outstanding I can't imagine any complaint, these nurses are rushed of their feet, they don't have breaks", and "The nurses are wonderful I think they are quite stretched but they are very kind and work hard".
- 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. For example we observed that curtains were drawn using large pegs to keep curtains closed when patients were receiving personal care.
- Patients we spoke with told us they felt safe in the hospital.
- We looked at the results of the patient led assessments of the care environment (PLACE). The trust scored 93% for privacy, dignity and wellbeing which was better than a national average of 87%. A patient told us "The ward is excellent, the food's good and there is plenty to drink. The nurses are very nice, I hadn't noticed if standard drops off at night, staff look like they are enjoying what they are doing." Another patient told us "I've know this place since I was a kid, it's always been our hospital, we've always been here and had the service we wanted".

Understanding and involvement of patients and those close to them

- Patients we spoke with 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 or injury might improve or progress. Positive comments we received were "Doctors keep coming round at each stage of treatment. They have briefed me", "Doctors have told me all I want to know."
- We observed nurses, doctors and therapists introduce themselves to patients and involved them in decisions about their care. On one ward we observed an occupational therapist discussing with an elderly patient the services being put in place to get them home , which included having a hospital bed delivered and a care package that was due to start when they were discharged.
- Relatives we spoke to were happy with the care their relatives received and felt that they had been kept involved with their loved one's treatment. On Mark ward

staff reported that there was a drop in clinic for relatives each Monday between 5pm and 6pm to meet with the consultant and the ward manager. We were advised this was well attended and worked well.

- On the care of the elderly wards we saw that relative passports had been introduced which enabled the carer to become actively involved in decision making and caring for their relative. This enabled relatives to visit their loved ones out of hours and assist at meal times to support them. It also gave the carers some concessions to discounted car park fees and hot food in the hospital canteen.

Emotional support

- Patients and their relatives told us that the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- 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?

Outstanding ☆

We rated the responsive aspects of medical services as outstanding

The acute admission ward was overseen by multidisciplinary medical teams. Clinicians and therapists were involved with patients at the point of referral, undertook assessments and provided a rapid response to patient needs. The ward incorporated frailty and ambulatory care models to reduce unavoidable admission and improve early discharge.

The trust proactively managed patients discharge. Discharge plans were commenced on admission and patients had an estimated date 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 patients 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, 79% (21,405) of patients experienced no ward move, 18% (4,888) of patients were moved once, 2% (664) of patients were moved twice, 116 patients were moved 3 times and 25 patients were moved four or more times. This demonstrates 79% of patients were treated in the correct speciality bed for the entirety of their stay. Senior staff reported they would try not to move patients after 6pm of the evening.

Patients had their needs assessed and fundamental care rounds were undertaken at different times of the day. Specials 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 acute medicine service reported good working relationships with the clinical commissioning group's (CCG's) for Lambeth and Southwark in developing integrated services for patients linking the community services to acute provision designed to move patients through the hospital into community based provision.
- The hospital had recently opened a new 60 bedded acute admission ward for the emergency access pathway which incorporated ambulatory care and frailty models with the aim to reduce hospital admissions, facilitate early discharge and improving patient flow through the emergency department, acute admissions unit (AAU) and the medical wards.
- Plans were in place to reopen one of the acute medicine wards for elderly patients which had been closed following the opening of the admission unit to assist with winter pressures. Demand for medical beds frequently outstripped supply especially in the winter period.

Access and flow

- Once patients had been seen in the ED and deemed to require admission, they were transferred to the recently opened 60 bedded acute admission ward which was overseen by multidisciplinary medical teams. Clinicians and therapists were involved with patients at the point of referral, undertook assessments and provided a rapid response. Patients who were medically stable and

needed to stay in hospital longer than two or three days were transferred straight to the wards. Ward staff on the elderly care wards reported that use of the frailty model resulted in them admitting patients sooner and helped to improve the patient experience. One patient told us that they had come in to ED that night (4am) with chest pain, were seen straight away and brought to the admission ward at 6.00am. The patient had been seen by a cardiologist and was waiting for test results by 9.45am.

- The acute medicine service reported that since the acute admission ward had opened most patients had been discharged within 48 hours. There were in reach from specialist medical teams and regular multidisciplinary board rounds to identify patients' needs prior to discharge.
- In order to expedite discharges of patients with no current acute medical needs, patients were discharged to the 'hospital at home' service. The hospital at home service had a team of specialists who supported patients in their own home.
- Discharge plans were commenced on admission and patients had an estimated date of discharge documented in their records. On wards designated discharge nurses would oversee patients discharge arrangements. On care of elderly wards we saw that ward based social workers undertook assessments of patients' needs such as those requiring care packages. Discharge arrangements were discussed at daily board round meetings. However we found that on Stephen ward no discharge dates were on the ward board or in patient notes. We spoke with two patients and they were not aware of their estimated date of discharge. Staff reported patients would be given a discharge letter; these were electronically generated and were also sent to the patients GP.
- To prevent delaying the time of discharge blood test were done the night before so consultants had results in the morning and TTO's were ordered to arrive on wards the day before patients waere discharged.
- Situation report meetings operated four times a day to establish where there was bed availability on the wards across both sites with the two hospitals communicating via video conferencing. We observed the morning meeting at 10.00am. Ward staff reported the number of discharges planned and the discharges anticipated later in the day of the following day. Where a patient 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, 79% (21,405) of patients experienced no ward move, 18% (4,888) of patients were moved once, 2% (664) of patients were moved twice, 116 patients were moved 3 times and 25 patients were moved four or more times. This demonstrates that 79% of patients were treated in the correct speciality bed for the entirety of their stay. Senior staff reported they would try not to move patients after 6pm of the evening. Across the trust a total of 36 patients were moved four or more times.
- During the period April 2013 to February 2015 the trust exceeded the 90% target for referral to treatment (RTT) waiting times for patients starting consultant led treatment within 18 weeks of referral. Within medicine Cardiology achieved 94.8%, Dermatology 93.8%, Gastroenterology 98.3%, General Medicine 93.9%, Older person Medicine 99.4%, Neurology 100% and Rheumatology 98.1%. The trusts over all performance was consistent with the England average.
- At the time of our inspection 51 patients across the trust were outliers (patients who were under the care of a consultant but looked after on a different ward). These patients were seen daily by the medical teams looking after them.

Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed 14 sets of patient records and saw that 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 their bedding changed.
- The acute medicines service held a managing complex patient summit on April 2015 to discuss the small number of complex patients who utilised the services of acute medicine. It was attended by 25 staff from different multidisciplinary teams from the community and the trust. The minutes of the meeting showed there were a number of agreed outcomes from the meeting.

Medical care (including older people's care)

- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care. These staff offered appropriate support to patients, their families and carers in relation to their psychological needs.
- Following feedback from patients the hospital had introduced a sleep soundly in hospital campaign. On wards we patients were issued with non-slip bed socks, eye masks, and ear plugs to help reduce the noise on the wards at night. Patients who were at risk of falls were offered red bed socks.
- Nursing Assistance were specifically trained as 'specials' to support patients who had complex needs. We saw the specials were utilised across the medical wards overnight and during the day. We observed specials sitting with patients to ensure that the patient did not fall out of the bed. On one of the care of the elderly wards we observed a special walking with a patient who was wandering around the ward, the special was quietly talking to the patient as they walked. This meant that the patient who was a falls risk was being monitored and kept safe. The specials had been trained in distraction techniques for example encouraging a patient to play a game. The number of specials were reviewed daily and patients' needs assessed for that the wards could safely manage the risk.
- On wards we saw that communication boxes were available for staff to access with games to distract patients and communication tools such as pictorial aids.
- There were arrangements to ensure the requirement that all patients aged over 75 years were screened for dementia within 72 hours of admission. In May, June and July 2015 over 90% patients were screened for dementia within 72 hours.
- The elderly care wards were dementia friendly, using colour coding so that patients living with dementia would be able to recognise the facilities they could use. This meant patients could easily identify which bay they were in. 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 observed a nurse redirecting a patient to their bay with reference to the colour. The wards also provided single sex accommodation with designated male and female facilities close to the single sex bays
- Patients living with dementia were identified with a 'forget me not' symbol on ward boards and on the wards would be in eyesight of staff with staff not leaving the bay. On wards we saw confused patients observed by with 'specials'. 'This is Me' document designed to obtain information to assist staff in providing care designed to meet the individual's needs of those living with dementia had been completed. Staff told us that they worked closely with the dementia and delirium (DaD) team who supported them on the wards. Staff had completed dementia awareness training and there was written information available for staff on how to communicate effectively with people living with dementia..
- Patients received welcome information about the ward when they came on to the ward. This included information on visiting and meal times, what clothes to bring, and discharge arrangements.
- Patient passports were in use for patients with a learning disability which were completed by their relative or carer. The passports were used so patients could outline their care needs, preferences and any other useful information the staff would find useful to assist with their care.
- Staff reported that they could apply to the trust charity to assist patients, one example staff gave was of a patients who discharged was to be delayed as they needed to store some of the furniture to ensure that patient could move safely around their home. Through the trust's charity staff were able to purchase a shed so that the patients furniture could be stored.
- Staff reported that they were able to able to access translation services for patients whose first language was not English. Staff could book interpreter which oculd be provide over the telephone or face to face.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Staff directed patients to the 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 senior ward nurse or manager via phone and email. Complaints would then be investigated and the complainant would receive feedback with details of action taken.

- Ward staff told us that they received very few formal complaints. The acute medicine performance review showed that a total of 19 complaints were received between January and December 2014.
- We noted that 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

We rated the well-led aspects of medical services as good.

Staff were aware of the trust and acute medicine 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 one of openness and honesty.

There was an appropriate system of clinical governance in medical services that identified quality and risk issues. 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 and executive managers were visible on the wards. Medical staff reported that they felt supported by their senior colleagues and had opportunities for further development. Staff felt informed and involved with the day to day running of the service and its strategic direction.

We found staff and patients were engaged with the development of medical care services and saw examples of innovative practice.

Vision and strategy for this service

- Senior staff within the acute medical services had a clear vision on how the service was to move forward. The emergency access pathway, which included the redevelopment of the ED and the new 60 bedded admission ward, provided the opportunity to develop an integrated care model bringing the acute and community services closer together.
- Senior staff were aware that that they needed to retain medical and nursing staff within acute medicine and saw the development of the emergency access pathway within the hospital as an opportunity to enthuse staff about looking after acutely ill patients. They were looking to increase the number of band 6 nursing staff to help with career progression within care of the elderly and general medicine.
- Ward staff reported that the frailty model had made a difference to the patients on the care of the elderly wards, as patients were getting to the wards sooner which meant that did not have to explain their story so many times.
- Staff were aware of the trust wide vision of 'safe in our hands'. For staff on the wards this meant providing the best care possible for patients, which meant making sure that patients were happy with their care, they were safe and comfortable.

Governance, risk management and quality measurement

- Acute medicine clinical governance committee meetings were held monthly and attended by senior staff including the clinical director, clinical leads and head of nursing. There was also representation from ward matrons, a dementia and delirium nurse specialist, pharmacist and senior site nurse practitioner. We reviewed the minutes from the four meetings between February and June 2015 which showed there was a comprehensive review of on-going issues. We saw how these meetings had been used to share information about complaints and incidents but also to share good practice and positive feedback.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.
- We saw that 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 for the area who monitored for themes and trends.
- We spoke with the ward managers across all medical services who demonstrated a good awareness of

governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a ward based risk register and undertaking audits.

- We looked at the risk registers and noted all the risks we had been informed of were included. We saw that there was a named manager responsible for the risk, with details of the action taken to mitigate the risks that showed that progress was recorded demonstrating active management of identified risks.

Leadership of service

- The clinical director worked closely with the heads of nursing for medical care. The clinical director and the heads of nursing assumed responsibility for a number of governance issues in addition to shaping the vision and strategy of the service.
- Ward staff told us matrons and senior staff could be seen on the ward regularly and they were approachable and helpful. We observed that senior managers knew the staff. Ward sisters reported they had a lot of support and felt able to ask for additional support if they needed it. Other staff reported that the chief nurse was seen regularly on the wards and had recently worked a night shift on two wards.
- 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 to the matron. Staff were moved between wards within their acute medicine to ensure that nursing levels and the skills mix on the wards were safe.
- Staff told us that they felt supported by their line-manger to do their jobs; they had clinical supervision and some staff had had their annual appraisal.
- Leadership at local service level was good. Staff told us they were supported by their managers and department heads. Senior managers, 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 we spoke with told us they felt there was excellent communication between medical and nursing staff.
- Junior doctors reported that they were supported by senior staff and could work across both hospital sites. Consultants assisted with their training and arranged additional training in other medical specialities; for example attendance at respiratory clinics. This gave junior doctors further learning opportunities and experience.
- On wards staff had opportunities to develop; nursing staff had link roles and undertook different functions on a rotational basis. For example overseeing the ward discharges, responsible for patient nutrition. Nursing staff would also take responsibility for running the shift and would wear a red arm band to indicate that they were the nurse in charge.

Culture within the service

- Staff reported that they were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work. Some nursing staff we spoke with told us that they commuted in from different parts of the country to work for the trust because they enjoyed working at the hospital and felt they had opportunities to develop.
- Staff reported that they were comfortable reporting incidents and raising concerns. They described the trust as having an open culture and said they were encouraged to learn from incidents.
- We spoke with the clinical lead who described the culture of consultants as positive, collaborative and proactive with increasing involvement in clinical leadership and in quality and governance initiatives.
- On wards we observed that staff embraced multi-disciplinary working which involved patients' relatives, therapists and nursing staff working together to achieve the good outcomes 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 which included surveys such as the friends and family test and inpatient surveys. In addition, staff reported that they regularly canvassed patients to ensure they were happy with the treatment and care they received.

- Staff reported that they had regular team meetings and we saw different examples of ward newsletters for staff 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".

Innovation, improvement and sustainability

- The admissions ward had only been open for five weeks when we inspected the hospital and was integral to the emergency access pathway that was being developed. Patient pathways through the hospital were being improved and it was anticipated that, along with frailty and ambulatory models, this would reduce the length of time patients stayed in hospital and that patients who needed to be admitted had timely transfers to the right wards for their on-going treatment.
- We saw that careful planning had gone into the environment of the admissions ward. For example not all the bays had natural light so light boxes were installed to replicate day light hours, and patients who were confused or living with dementia were placed in bays near natural light. The flooring was soft to reduce injury due to falls.
- Senior staff reported that they had to achieve a cost improvement of £4 million across the service and they had identified £2.5 million worth of savings by for example reviewing existing posts, developing new posts and re-grading were appropriate. The trust was anticipating a deficit for the current financial.
- We found through our discussions with all grades of staff that staff felt informed and involved with the day to day running of the service, and its strategic direction.

Surgery

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

Information about the service

Surgical activity is delivered across five directorates at the trust:

1. abdominal medicine and surgery (AMS) which includes dialysis, gastroenterology, hepatatology and endoscopy, kidney and pancreas transplantation, general and acute surgery, lithotripsy and endurourology, renal medicine, robotic surgery, specialist cancer services, upper and lower GI surgery and urology. Income for the directorate is £130million a year.
2. cardiovascular services, which includes cardiac surgery, cardiology, and vascular surgery. Income for the directorate is £85 million a year.
3. Surgery which includes plastics, trauma and orthopaedics. Income for the directorate is £48 million a year.
4. oncology, haematology and cellular pathology which includes breast surgery, ENT, head and neck and thoracic surgery.
5. perioperative, critical care and pain directorate manage the theatres.

There are approximately 170 beds for surgery patients across 10 wards and 20 theatre operating suites.

Emergency and elective surgery including vascular, colorectal, cardiac and plastic surgery are predominantly carried out at the hospital. For this inspection we focussed on the AMS and cardiovascular directorates and theatres. For more details on trauma and orthopaedics please refer to the Guy's Hospital report.

The service saw 22,313 patients stay between January to December 2014. The 'hospital provider spells', which identify the continuous stay of a patient using a hospital bed, identified that within surgery 45% were patients who had day surgery , 23% elective or planned surgery needing to stay in hospital for more than a day and 32% were emergency surgical patients.

We visited all pre-operative assessment areas, the pre-admission ward, surgical assessment lounge, anaesthetic rooms, some of the theatre suites including the emergency and day theatre, recovery and all surgery wards except Howard ward (ward for privately funded patients) and Alan Apley (plastic surgery).

We spoke with more than 30 patients and visitors and more than 60 members of staff working at different levels within the service. We reviewed computer systems, documents and patients records. We observed care being given and interactions in clinical and non clinical areas. We checked some equipment.

Surgery

Summary of findings

There was a clearly defined vision and strategy for each surgery service that included working with other directorates and other organisations to provide the best health outcomes for all. There was strong clinical leadership with visible presence and nurses were empowered.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. Quality improvement was a part of all staffs daily roles and all staff were continuously striving to improve services.

Patients were supported, treated with dignity and respect and involved in their care and treatment. Patients told us that the care was kind, compassionate and they felt listened too. We observed a number of interactions where patients and their families were involved in their care and helped with their emotional needs. The average response rate to the friends and family test was 35% with respondents most commonly recommending the service.

There were sufficient numbers and mix of all staff to provide safe care. There was good retention of nursing staff and management of turnover. There was a very low use of bank and agency nurses. Staff were qualified and had the skills and expertise to carry out their roles effectively in line with best practice. Care was coordinated and staff were worked collaboratively to understand and meet the needs of patients.

There had been eight never events in 16 months, however we found an open culture of learning from incidents. The World Health Organisation (WHO) safer surgery checklist had not been fully implemented.

Staff were knowledgeable on the needs of their local population and service users. Access and flow was well managed by the service by working with the whole hospital. Waiting times and cancellations were minimal.

Are surgery services safe?

Requires improvement

Summary

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. Audits of compliance with the three steps that had been implemented showed an improvement in compliance but more work was needed for all areas to be fully compliant.

There were sufficient numbers and mix of all staff to provide safe care. There was good retention of nursing staff and good management of turnover. There was a very low use of bank and agency nurses. There was appropriate consultant cover arrangements for nights and weekends.

Wards were clean and well organised, and there were effective infection prevention and control procedures in place.

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 in sharing information between directorates that deliver surgical activity. There had been eight never events in 16 months.

Learning from incidents

- Between April 2014 and August 2015 there were nine (one in dental services which we did not inspect) reported never events (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) across the directorates that delivered surgical activity. Of the eight included in the services we inspected this included five incidences of retained foreign objects post operation, two incorrect implants and one wrong site surgery. Within each directorate we found staff were aware of the never events and actions taken. Action taken included 'stop before you block'

audit and recommendations had been rolled out to minimise operating on the wrong side of a patient. All senior staff were aware of the learning from never events from surgical activity in other directorates, but not all other staff. Senior staff recognised and had raised that formal sharing through the coordination of the quality and safety team was needed. For example changes made to identifying equipment packaging in response to a never event in cardiovascular were also applicable to the surgery directorate.

- Nearly all staff had reported an incident and/or a near miss and told us the feedback and action taken following incidents. From September 2014 to August 2015 there were 21 reported serious incidents, of which seven were pressure ulcers.
- 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. Themes were analysed and changes made.
- Mortality and Morbidity meetings were detailed and held monthly. The minutes demonstrated that discussions were highly supportive and highly challenging.
- In the cardiovascular directorate all deaths were reported and reviewed by clinical panel. The clinical panel decided if a root cause analysis investigation was needed or review at Mortality and Morbidity meetings.

Duty of candour

- Duty of Candour was a part of all staff practice. Staff had been trained in the regulation and found it underpinned their open and honest culture.

Safety thermometer

- All wards continuously achieved 95% or above compliance with harm free care in all areas measured.
- Safety thermometer information was displayed in each of the wards we inspected on 'How are we doing' boards and 'Safe in Our Hands' boards. The topics displayed were chosen by the ward sisters as being the most relevant to their ward.
- 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).

Cleanliness, infection control and hygiene

- The Surgery Infection and Prevention Control scorecard reported zero incidents of blood infections or C. Difficile from 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 NIHCE guidelines (CG74). All elective patients were assessed for MRSA before their procedure. There were IPC liaison nurses in theatres who had completed infection prevention and control training.
- Theatres and recovery were clean, tidy and well organised.
- Waste segregation, storage and disposal were managed in line with Department of Health guidance.
- We saw staff observing isolation protocols and personal, protective equipment readily available.
- Patients were satisfied with the cleanliness of the hospital. We saw cleaning staff proactively cleaning and they were clear on their cleaning duties.
- 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 the inspection team observed a couple of members of staff (doctors and administrative staff) that were not bare below the elbows and did not use the handgel when expected too on the wards. We raised this with ward managers at the time of the inspection.
- Hand hygiene and isolation audits were completed monthly by IPC link practitioners throughout the surgical specialties. Service managers reported that infection prevention and control audit outcomes were presented at multidisciplinary board meetings.
- Gloves and plastic covers were available at the entrance to each of the wards we inspected. Alcohol gel was available to visitors.
- 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 substance hazardous to health (COSHH) and health and safety posters were on the walls in the sluice and around the wards we visited.
- Some wards had 'infection, prevention and control link nurses who were available for advice and support and staff reported that the champions were useful.

Environment and equipment

- All of the wards we visited were well organised, clean and bright. Patients and staff told us they had or could access the equipment they needed.
- 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, led by the trust's facilities, estates and IT directorate. The group incorporated IT services, estates and facilities. The initiative was designed to improve the system of repairs across the trust. Maintenance staff visited each ward and clinical area weekly to pick up any required repairs.
- All equipment we checked was clean and had up to date 'I am clean' stickers to demonstrate that they had been sanitised.
- Theatre staff reported having enough equipment in theatres.
- Resuscitation equipment was well maintained and accessible. We checked the equipment in the recovery suite, Doulton ward, Sarah Swift ward, Page ward and Northumberland ward and all equipment was in date and ready to be used if needed.

Medicines

- Patients' own medicines were locked away and patients were knowledgeable about their medicines and the risks.
- We saw medicines being managed safely by pharmacists.
- We found controlled drugs checks were fully completed on the wards we checked – recovery suite, Doultan, Sarah Swift and Northumberland.

Records

- The hospital was rolling out electronic recording (E-noting) and was nearly paperless. Staff were supported to use the electronic systems and were satisfied that electronic reporting was clearer, faster and safer for patients.
- Patients were risk assessed on admission, including Waterlow score, VTE assessment and identification of tissue viability. All elective patients had a pre-op assessment. The admissions documentation we reviewed for emergency and elective patients 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, occupational therapy and social care 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.
- Where electronic notes were available, we found that the system worked effectively for the most part, however, nurses told us that sometimes they could not enter observations contemporaneously as they were unable to open the relevant 'page' because it would not load. The IT risks such as connectivity, computers being charged were recorded and being mitigated.
- We checked a sample of paper patient records on each ward and found that the majority were completed, legible and up to date. Paper notes were stored in safe, visible note trolleys by the nurses station.
- We checked nine fluid balance charts and all had been completed, howver the totals wer enot always calculated. Paper notes were used to record if and when nurses had encouraged patients to drink more water.
- 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

- All staff were aware of how to identify potential safeguarding issues and how to report them. Staff that had been in involved in safeguarding told us the appropriate actions they had taken.

- Safeguarding was part of mandatory training and more than 85% of staff had completed their training.
- Surgeons were trained to Level 3 – the highest level of training for safeguarding.
- Some wards had 'safeguarding champions' who were available for advice and support and staff reported that the champions were useful.
- 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

- Mandatory training rates were between 85% and 100% for all staff.
- Staff were clear that it was their responsibility to keep up-to-date and line managers discussed training at one to ones and teams meetings. We saw team leaders had a system to check that their staff were trained including bank and agency staff.

Assessing and responding to patient risk

- The 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. The recording and escalation of early warning scores was audited. 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.
- An escalaton process was in place in the recovery area if a patient suddenly deteriorated and the recovery nursing staff were aware of this process. Nurses were trained in recognising a deteriorating patient.
- On Page ward we found a patient whose condition had deteriorated and it had not been appropriately escalated to the clinical site team. We spoke with staff involved and found some action had been taken and there was a gap in recording the observations. We saw the patient was recovering well.

Use of the 'five steps to safer surgery'

- The trust had taken a staged approach to introducing the World Health Organisation Surgical Safety Checklists. The three central steps had been introduced in 2010 and the remaining two in May 2015 but they had not yet been fully implemented in all theatres.
- Three (sign in, time out, sign out) of the five steps to safer surgery were embedded in practice. Step one, briefing and step five debriefing did not always happen and there were plans to ensure these steps were always carried out.
- Observational audits of the three steps were carried out in August 2015 and showed overall compliance at 90%. This was an improvement from 81% in February 2015 however more improvements were needed. Surgical teams were not aware of whom and if an observational audit was being carried out. In 100% cases observed, at least one stage of the checklist was carried out. Both day surgery units noted a small improvement in compliance. There was a decrease in compliance in all other areas, most notably in cardiac theatres, where compliance dropped from 100% in 2014 to 59% in 2015. Nine out of 20 specialities were 100% compliant with completion of the checklist. The audit identified good engagement of nursing staff in the checklist, with nurses leading all three stages more frequently than other staff groups.
- The directorates had reviewed their audit data and were working on improving compliance one example being covert observational audit.
- Staff had been made more aware of the correct site surgery policy which refers to operating on the correct side of the patient and/or the correct anatomical location or level following a Never Event.

Nursing staffing

- Patients told us that overall they felt there were enough nursing staff.
- Every day wards displayed the number of staff needed on the shift and the number of staff actually on shift. The results for a month were displayed and on most occasions staffing the actual numbers of staff was sufficient.
- During our inspection all wards were safely staffed with nurses and nursing assistants.
- Nurse staffing requirements were identified according to National Institute of Health and Care Excellence (NICE) guidance, using patient acuity level data. Staffing records documented 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.
- 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.
- The hospital target for sickness rate was 3% or less monthly. For 2014/15 the AMS average sickness rate was 3.9%, for cardiovascular it averaged 2.5%, for surgery 3.5% and 2.5% in oncology and haematology.
- We observed two handovers. All aspects of patients care was discussed in a structured way to ensure staff understood the needs of their patients.
- Agency staff were recruited from one agency to ensure checks, training and continuity staff where possible. Agency staff were inducted to the trust and there were documented inductions on wards. We spoke with a few agency staff who felt part of the team.

Surgical staffing

- Patients told us they saw their doctors often and they came when they requested them.
- We saw surgical staff available to patients and other staff groups throughout our inspection.
- Overall the staffing levels were favourable compared to the national average. There were 525 whole time equivalent staffing of which 41% were consultants (same as the national average).
- 2% middle career (at least three years' experience with chosen surgical specialty), This was 9% worse than the national average.
- 48% registrar group better than the national average of 37%.
- 10% junior doctors slightly worse than the England average of 10%.
- Senior managers reported infrequent use of locum doctors across surgical directorates.
- 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. Higher specialty doctors in training were resident at night and consultants were on call during out of hours. Consultants and registrars shared weekend cover, however some emergency patients may be seen by middle grade doctors at weekends.
- At 20:00 the emergency surgeons completed handover to night consultants, in the morning handover was completed but it was more variable depending on the demand during the night.
- Doctors in training did not identify problems with their rotas.
- Daily ward rounds were consultant led. We observed sufficient presence and input by consultants and doctors in training at handover and ward rounds
- Clinical leaders within the surgery service highlighted the impact of recent changes to the surgery training post allocations in London. The surgery service had introduced a new structure with specialty trainees and physician assistants filling gaps previously held by Foundation Doctors. Surgery had appointed five

physician assistants and several nurse practitioners to manage service delivery, but clinical leaders recognised that the ongoing reduction in surgery training posts will require further changes to service provision in the long term.

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. Nurses gave 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 it.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures
- The protocols for major incidents in theatres were comprehensive and senior staff knew their responsibilities.
- There had been a major incident in the last month when on a Sunday there was a water incident that had caused an electrical fault. The protocols were followed and the problems had been made by the Monday. The clinical site management team had reviewed what happened and if anything could have been done differently in the future.

Are surgery services effective?

Good

Summary

Patients received care and treatment in line with evidenced based care and treatment.

There was participation in local and national audits. The information collected was used to improve care and outcomes for patients. Mortality following surgery was lower than expected. However outcomes were variable – good in the lung cancer audit but poor in the National Emergency Laparoscopy audit.

Staff were qualified and had the skills and expertise to carry out their roles effectively in line with best practice. Care was coordinated and staff were worked collaboratively to understand and meet the needs of patients.

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 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 and post-operative rehabilitation services were provided in line with NICE CG83 guidance.
- The trust's central governance team was responsible for the production and management of all surgical protocols with input from specialist nurses, clinicians and referenced current national guidance. 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 meetings in each directorate. AMS had an increasing number of new guidelines to keep up-to-date with. .
- 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.

- All appropriate patients were on enhanced recovery pathway to reduce the amount of time spent in hospital. The principles of enhanced recovery pathways were used with all patients.
- Local audit activity was variable. Standard audits such as monthly hand hygiene and sharps audits were conducted, and WHO checklist audits were conducted every six months. Most local audits relied on junior doctors completing them and they were not always completed before they moved on to new placements.

Pain relief

- Patients were satisfied with their pain relief. They said it was being managed and if they required more support they got it quickly.
- We saw patients were assessed for their pain relief during their pre-operative assessment. Further checks were made on the day of the operation in case any changes had occurred.
- A standard procedure was followed to provide patients with a fractured neck of femur fast pain relief.
- Nurses asked patients at least every two hours during the day about their levels of pain.
- There was a dedicated pain team that saw all patients assessed as needing additional pain relief

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.
- There were mixed views on the quality of the food from the patients we spoke with. There was range of choice and staff offered alternatives where possible.
- 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.
- Some wards had 'nutrition and hydration champions' who were available for advice and support and staff reported that the champions were useful.

Patient outcomes

- The hospital standardised mortality ratio for deaths after surgery was lower than expected. The mortality rates were among the best in the country.
- The service performed better than England and Wales national average in all areas of the lung cancer audit 2014.
- The service had mixed results in the bowel cancer audit 2014. One hundred per cent of patients were discussed by a MDT but 71% were seen by a CNS and 71% had a CT scan reported compared to 88% and 89% of the England average.
- In four areas performance in the hip fracture audit had improved from 2013 to 2014. Admission to orthopaedic care within four hours, bone health medication assessment, falls assessments and total length of stay were all better than the national average. Performance in three areas were worse than the England average: surgery on the day of or after day of admission (65% compared to 74%) pre-operative assessment by a geriatrician (39% compared to 52%) and patients developing pressure ulcers (4.6% compared to 3%).
- In the patient reported outcome measures, fewer patients who had undergone procedures for groin hernia and varicose veins reported improvements compared to the England average. Patients who had undergone hip and knee replacements reported improvements similar to the national average.
- In 2014/15 the hospital target was for more than 85% of day surgery. AMS day surgery rates averaged 58%, Cardiovascular day surgery rates averaged 99%, surgery averaged 81% and oncology and haematology averaged 84%. Day surgery rates were worse than the England average. Senior staff recognised that day surgery could be utilised more in some cases.
- Theatre utilisation averaged 95%. It was closely managed and all staff were involved in ensuring theatres were used effectively with minimal time wasted.

- For emergency patients the risk of readmission following surgery was better than the national average. However the risk of readmission for patients having planned operations was worse than the England average. Clinical directors were continuously reviewing the reasons for readmission.
- The national emergency laparotomy audit 2014 identified shortfalls in 11 out of 31 areas looked at. In response the lack of leadership had been addressed by recruiting two emergency surgeons who led on the ongoing data collection and improving performance.

Competent staff

- There were effective processes for annual appraisals for all staff. All of the staff we spoke with about appraisal had received an appraisal within the past year and found it useful. On some wards, senior staff showed us data that supported most staff had been appraised. 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.
- Service managers reported access to a limited training budget, 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. The trust contributed to fees for further education, and staff could apply for one year secondments and transfers to other directorates.
- 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 cannulatioin, phlebotomy, dementia awareness and conflict resolution.
- Theatre staff told us they were encouraged to develop and were provided with opportunities for training. Access to university courses included top up modules on anaesthetic nursing, theatre nursing, recovery nursing and mentoring. Internal courses in leadership and cardiac nursing were available.
- 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. The Locum doctors induction programme covered all aspects of day to day working in specific areas and had up-to-date contacts.
- The hospital was a Nursing and Midwifery Council (NMC) pilot site for nurse revalidation. [Information on revalidation for clinicians was trust wide].

Multidisciplinary working

- Patients were put first and staff from all groups – medical, nursing, allied health professionals, pharmacy worked together to ensure the patients' needs were met. Internal MDT working was embedded in practice and we saw staff groups working together.
- The trust's established POPS team was 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 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.

Seven-day services

- All appropriate specialities provided elective surgery six days a week.
- There was consultant presence out of hours and all patients were seen daily including weekends by a consultant.
- Out of hours support services including imaging, pharmacy, physiotherapy and occupational therapy were available.
- Stoma services were available six days a week.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff. Some areas had implemented electronic records and staff reported this new way of working was successful and more efficient.
- 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 GPs in various ways and there was a working group with local GPs to improve communication. From the 1 October 2015 fax was not to be used. The CCG reported that GPs were satisfied with the communication 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

- Patients said they had consented to their operations and could detail what had happened to them and the risks and benefits. However we looked at approximately 10 records of the patients we spoke with and found most were illegible including the doctor's printed name, some lacked detail and all of them contained the patient's copy of the consent form. Senior ward staff said they gave patients their copy of the consent form on discharge.
- The hospital audited consent forms and processes in 2014, and delegated consent in 2015. The Trust Risk and Quality committee (TRaQ) reviewed the overall audit results with the policy. The audit of 279 surgical patients records showed improvements were needed in legibility and evidencing information given to patients. One of the recommendations of the audit was to remind staff to give written information and offer copies of consent forms. 241 surgical patients were asked about the consent process and nearly all patients responded that their procedure including the risks and benefits were explained to them and clinicians could answer their questions.
- Most staff were aware of what action to take if they thought patients lacked capacity and needed support. Mental Capacity Act 2005 training was part of mandatory training, and some key staff were champions in Mental Capacity Act 2005 which meant they took more of an interest in the area and shared their support and advice with other staff. Staff reported that the champions were useful.
- 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.
- During our inspection no patients were deprived of their liberty. Senior ward staff said they would seek guidance form designated staff if patients needed to or were deprived of their liberties.

Are surgery services caring?

Good

Summary

Patients were supported, treated with dignity and respect and involved in their care and treatment. Patients told us that the care was kind, compassionate and they felt listened too. We observed a number of interactions where patients and their families were involved in their care and helped with their emotional needs. The average response rate to the friends and family test was 35% with respondents most commonly recommending the service.

Compassionate care

Surgery

- We saw and were told that all staff were compassionate and caring.
- The response rates for the Friends and Family test results for the surgical wards ranged from 30% to 49%. The average was 35% compared to the national average of 37%. From March 2014 to February 2015 the percentage of patients that would recommend the service ranged from 87% to 100%. Most frequently 100% of respondents recommended the service.
- We saw on all wards we visited lots of thank you cards and letters. Display boards showed recent comments from patients and visitors.
- There were hourly rounds 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. Patients said staff were always available if needed them.
- We saw privacy and dignity was always respected by all groups of staff with closing of curtains and conversations being held in private.
- A number of patients commented that they knew the difference between permanent and agency nursing staff. Agency nursing staff were less likely to engage in conversation and were more task focussed. Senior staff were aware of the feedback and were working with agency staff to interact more with patients.

Understanding and involvement of patients and those close to them

- All patients were very knowledgeable about their care and treatment. They said staff had involved them in their care. There were a few occasions when communication could have been improved for example when nutritional needs had been agreed by the doctor and not shared with the catering staff.
- We observed a number of interactions where staff unwearyingly ensured patients understood and were involved in their treatment.
- A number of staff spoke more than one language and were available for interpreting for patients who spoke the same language in addition to language line. We saw staff accessing staff who could interpret to assist patients in their understanding and nurses working across wards if their language was needed.
- We saw privacy and dignity was always respected by all groups of staff with closing of curtains and conversations being held in private.

Emotional support

- The Dimbleby Cancer Care service provided emotional support on the wards for cancer patients. We saw staff visiting patients providing complementary therapy. Many patients told us they were offered emotional support from the service if they needed it.
- Aromatherapy was provided to a number of patients. We saw patients receiving aromatherapy and patients told us it made them feel calm and well-looked after.
- There were many clinical nurse specialists (CNS) providing specialist care and support. In the AMS directorate there were 40 CNS.
- Emotional care for vascular patients was described by patients and staff as being "world-class".

Are surgery services responsive?

Good

Summary

Patients' needs were met through the ways the services were organised and delivered. Staff were knowledgeable on the needs of their local population and service users

Access and flow was well managed by the service by working with the whole hospital. Waiting times and cancellations were minimal.

Patients knew how to raise concerns and complaints were investigated however, 37% complaints received related to surgical activity and more learning in a timely manner could be explored.

Service planning and delivery to meet the needs of local people

- Directorates delivering surgical activity operated at both Guys' and St Thomas' hospitals and had multiple outreach sites across South London to improve access for local patients. The directorates 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 reviewed 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.

- The cardiovascular directorate were clear on the needs of the local people and had developed plans to attract more patients from further afield due to their resources and the known demand in the South East. A side effect of the some of the cardiovascular services provided was erectile dysfunction. In response the service had started a clinic to treat the condition.
- 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). 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

- 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.
- Referral-to-treatment time (RTT) performance for admitted patients was similar to the England average. The target was for more than 90% patients to be seen within 18 weeks. For 2014/15 the AMS directorate averaged 77.7%, cardiovascular directorate averaged 89.5%, surgery directorate 89.3% and 95.4% in oncology and haematology directorate. There were dedicated staff and meetings focussed on improving the RTT pathway for all patients.
- Surgical bed meetings were held daily and attended by ward managers, senior staff nurses, surgical admissions staff nurses and site nurse practitioners. The meeting identified the location of any available 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.
- Cancellation rates were low. For the previous year the cancellation rates were 12% in the AMS directorate, 14% cardiovascular directorate, 7% in surgery directorate and less than 1% cancelled in oncology and haematology directorate.
- Less than 1% of cancellations occurred on the day of the operation. The three most common reasons for cancellations on the day were patient did not attend, patient unfit and patient decided not to go ahead with the surgery.
- The average length of stay (LOS) for all planned surgery was 5.5 days compared to an England average of 3.1 days. Senior staff monitored and discussed the reasons for the LOS being longer than the England average. LOS for planned operations in cardiac surgery was 10.1 days compared to an England average of 9 days, vascular surgery 6.6 days compared to an England average of 4.4 days and 6.6 days in colorectal surgery compared to an England average of 6 days.
- The average LOS for emergency patients was 5.2 days, the same as the England average. LOS for emergency patients receiving vascular surgery was 16.9 days compared to an England average of 11.9 days, colorectal surgery was 4.8 days compared to an England average of 4.6 days and 6.8 days compared to an England average of 8.5 days.
- 100% of Fractured Neck of Femur patients were seen within 24 hours. There were eight beds that were flexibly used for fractured neck of femur patients.
- Care of medical and surgical outliers ((patients who were under the care of a consultant but looked after on a different ward) was managed appropriately. There were daily 'sit-rep' meetings where patients on wards that didn't specialise in their condition 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. Wards had 'buddy wards', where possible cared for patients whose primary ward did not have a bed. This ensured a good use of doctors time and an increase in sharing expertise across wards.
- Straight to tests protocols in some surgery services ensured patients were seen and treated quickly.
- Readmission rates after specialised surgery for colon cancer had surged. When discussed with senior staff we found that the reasons had not been looked into in detail.
- 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.

Surgery

Meeting people's individual needs

- Most staff had large yellow badges stating "hello my name is…" they were clearly visible for all to read.
- Staff proactively considered and responded to specific individual needs, including cultural and religious needs. Pre-assessment screened for any learning disabilities which was recorded on the patient information and management system. Provision was made in the recovery area to allow patients with learning disabilities to see their carers immediately they were breathing by themselves following surgery.
- If a patient living with dementia was due for admission, ward staff would telephone 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 who had dementia awareness training and supported other staff on caring for patients with dementia.
- All staff spoke about how 'Barbara's story' (a dementia training film created by staff at the trust) had raised their awareness and impacted on their care of people living with dementia. For example one porter said it had made him more aware of trying to get eye contact when speaking with people.
- We saw patients' specific needs were confirmed by nurses during handover.
- Translation services were widely available and utilised. It was estimated that Language Line was used once per week. Some staff spoke a second language and were used for translation where required.
- 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.
- Local Spanish and Portuguese speaking communities using the surgery 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.
- 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.
- Patients told us they were reminded that they could attend the onsite cinema twice a week.

Learning from complaints and concerns

- Patients told us they knew how to raise concerns with their named nurse and felt any concerns had been listened to and rectified.
- From June 2014 to June 2015, 357 (38%) of complaints received related to the surgical activity directorates.
- The directorates had designated roles responsible for triaging and coordinating complaints and complaints were reviewed by the appropriate clinical staff. Most directorates had a complaints management system however, the abdominal medicine and surgery directorate at the time of our inspection 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.
- We heard many examples of changes made in response to concerns and complaints. One example was a relative had complained 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

Summary

There was a clearly defined vision and strategy for each surgery service that included working with other directorates and other organisations to provide the best health outcomes for all.

Surgery

Leaders were visible and had an inspiring shared purpose, that motivated staff to succeed. There was strong collaboration and focus on improving care and patients experience.

There was a proactive approach to seeking out and embedding new and more sustainable models of care. Quality improvement was a part of all staffs daily roles and all staff were continuously striving to improve services. We saw lots of innovation.

Vision and strategy for this service

- There were clear vision and strategies for each directorate that staff at all levels were involved in developing. Each directorate had visions and strategies for services documented.
- The clearly defined vision and strategy for the AMS directorate was to provide compassionate, innovative and responsive care that meets and exceeds the expectations of all patients across the entire portfolio of the local and specialist services. The service was to be characterised by the commitment to clinical and service excellence, development of a skilled and caring multi-professional team, enthusiastic support of research and training and collective determination to do things better.
- The clearly defined vision and strategy for the cardiovascular directorate was an increase in vascular surgery due to King's Health Partners integration, growth in cardiac surgery and a reduction in length of stay in all specialities.
- The clearly defined vision and strategy for surgery services was to deliver 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 surgical service for plastic surgery, trauma and orthopaedics.
- 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

- There were clear processes for escalating and cascading information. Monthly governance meetings fed into the performance review meetings and escalated to the trust risk assurance group that fed into the board. Staff in senior roles understood the escalation processes.
- We reviewed a sample of minutes from monthly staff meetings and governance meetings across surgery 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.
- It was not clear what the formal mechanisms were to share information and learning between directorates. Clinical governance facilitators in each directorate recognised this was a challenge and that they were looking at ways to share information between directorates more effectively. More support and coordination from the central quality and safety team had started.
- There were identified clinical governance leads in each directorate medical staffing to aid clinical engagement with governance.
- Clinical indicators such as falls, medicine errors and pressure ulcers were reported weekly through 'safe in your hands' meetings. There was 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.
- The medical director sent 'safety signals' each month which highlighted key safety issues that needed awareness. In theatres staff produced a RAG newsletter – Risk Audit and Governance to share important messages.
- 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.
- Performance review scorecards for each directorate covered all aspects of care and were produced and discussed monthly.
- We reviewed and discussed risk registers. Frontline staff knew how to report and escalate risk through their line manager and team meetings. Overall risks were managed appropriately and timely, however assessing and scoring VTE was a high risk for a substantial amount of time that needed attention. The senior staff were aware and had tried different approaches to improving the scoring but still found it variable and were looking for the next approach to improve.
- Quality improvement was a part of all staffs daily roles and all staff were continuously striving to improve services, for example the trust's 'Fit for the Future' programme.

Leadership of service

- Senior leadership was visible across the directorates. Senior level management were often described as excellent, responsive to problems, engaging and managed resources and vacancies.
- Leaders were supported to ensure they were competent.
- There was a proactive approach to seeking out and embedding new and more sustainable models of care. For example the vascular services.

Culture within the service

- Staff felt invested in, nearly all staff said they were proud to work at the hospital and that the investment in all staff made it a special place to work.
- We found the culture was open and honest – continually striving to improve and be the best for patients. We often were told "We can say we got something wrong, sorry and do better with support"
- Many staff had worked at the trust for a long time or had left and returned.
- The values of the trust were embedded.

Public engagement

- Members of the public were part of some committees where discussions and decisions to changes in services were had. There was a patient experience group made up of representatives that inputted into changes to the service. Improvements in the vascular service changes had been commented on by a number of patients.

Staff engagement

- There were a number of meetings and forums that staff attended and communication was proactive through emails, social media, intranet and notice boards.
- Staff told us leadership at all levels were visible and approachable.
- Clinical Mondays and clinical Fridays provided an opportunity for frontline staff and managers to work together

Innovation, improvement and sustainability

- An improving surgical productivity toolkit was being used to increase the number of patients that could be treated safely.
- The "productive operating theatre" had led to efficiency savings with staff spending less time on non clinical activities.
- The urology and vascular services were nationally recognised for innovation and complexity. Staff had visited other services and adopted some of their proven techniques such as reclining chairs for patients.
- The inflammatory bowel disease and the pelvic floor unit services had seen an increase in demand due to need and regional reputation.
- 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. Some quality improvement projects included 'safer faster hospital'
- The service was working with a national pharmaceutical company collaboration to improve length of stay.
- A 'Dragon's Den' was held by the executive where all staff could pitch ideas for improvement that required funding. New plate covers and a tissue viability app had been rolled out as successful dragon's den pitches.
- 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 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.

Critical care

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

Information about the service

Critical care at St Thomas's Hospital was part of the ninth largest critical care service in England and comprised of 65 beds. Management of critical care areas was the responsibility of senior staff within the Perioperative, Critical Care and Pain Directorate. Level three patients were cared for within East Wing 1 and East Wing 2 intensive care units, or within the overnight intensive recovery area. Level two surgical patients were looked after on Doulton high dependency unit (HDU) and Page HDU, whereas level two medical patients were cared for on Victoria HDU. Between April 2014 and March 2015, there were 2776 patients admitted across the critical care service.

Patients were admitted to critical care after becoming unwell on the hospital wards, via the emergency department or after surgery. East Wing 1 provided a specialist severe respiratory failure service and received referrals from other hospitals, often to commence extracorporeal membrane oxygenation (ECMO) with seriously unwell patients. A critical care response team was available to assess deteriorating patients on the hospital wards and to follow up patients stepped down from critical care.

We visited all areas of critical care over the course of three announced inspection days and one unannounced inspection day. During our inspection we spoke with 42 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team, eight patients and six relatives. We checked 15 patient records and many pieces of equipment.

Summary of findings

Overall critical care services were good, although some aspects of safety need to be strengthened. There was a proactive safety culture for reporting and learning from incidents. Critical care management were aware of on-going risks; these were recorded on the department risk register and largely reflected our inspection findings. Safety thermometer results and patient outcomes, particularly for patients receiving extracorporeal membrane oxygenation (ECMO), were good. Patients were cared for by safe numbers of staff, using evidence-based interventions. Caring staff obtained consent prior to procedures and maintained patient privacy and dignity.

The critical care service was flexible to the needs of patients and successfully used a "never say no" admissions policy. Few patients were transferred out of hours and the proportion of delayed discharges from critical care was better than in other similar units. The critical care environment was cramped in some areas and there were insufficient isolation facilities. These issues were being addressed with a HDU rebuild and a new critical care unit. Staff and patients were engaged in developing plans for the new units and providing feedback about the service.

Substantial participation in national and international research projects was apparent and we saw evidence of many departmental contributions to journal articles,

Critical care

book chapters and clinical guidelines. New innovations in critical care including telemedicine were being trialled and plans for formal implementation were in place.

Staff knowledge of safeguarding and Deprivation of Liberty Safeguards (DoLS) was variable across the service despite a high uptake of training in this area and safe practice relating to this 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.

Are critical care services safe?

Requires improvement

Safety within critical care requires improvement as, whilst there were a number of areas of good practice including incident reporting and medicines management, there was an increased risk of patient harm due to systemic issues relating to infection control. These included increased risk of patient harm, such as cross infection due to a cramped clinical environment and lack of adequate isolation facilities which met best practice recommendations. Hand wash facilities were not readily available in some areas and clinical waste bins were sometimes positioned some distance from bed spaces. In addition, the uptake of infection prevention mandatory training was low and some areas on Doulton HDU were not clean.

Furthermore, safeguarding was not given sufficient priority at all times and despite a high uptake of safeguarding mandatory training across critical care, some staff were not clear about safeguarding principles and were not aware of how to engage with local safeguarding processes.

Evidence of learning from incidents was visible throughout critical care. Safety thermometer results were good and suitable assessments were completed to determine patient risk.

Incidents

- Incidents were reported on a computer-based system which could be accessed from any trust computer, including computers found at patient bedsides. There were 411 incidents reported between February and May 2015. There were six serious incidents (four grade three and four pressure ulcers, a surgical error and one unexpected death) and one never event (misplaced nasojejunal tube) reported during this period.
- We noted fewer incidents were reported on Doulton HDU (three) and OIR (five) in comparison with other areas of critical care; Page HDU (20), Victoria HDU (55), East Wing 1 (112) and East Wing 2 (109). This could indicate fewer incidents occurred on these units or a less proactive safety reporting culture.
- Staff across critical care, including Doulton HDU and the overnight intensive recovery (OIR), were able to identify how to report incidents and the types of situations

which should trigger incident report completion, including near miss situations. Staff told us almost all incidents were reported but sometimes there was a delay in completing the report due to busy shifts.

- Incidents classified under critical care were investigated in three streams; medical, nursing and medication. Each stream had a different allocated clinician to lead the investigation. We saw evidence of investigation reports, witness statements and root cause analysis (RCA), including action points. However, 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. 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.
- Medicines 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.
- An online survey was sent to all trust critical care staff in June 2015 to gauge the approach towards safety within critical care and achieved a 60% response rate from a range of professions. Results we reviewed showed a positive approach to safety and suggested staff knew how and when to report incidents, which supported our inspection findings.
- Staff told us they received feedback and learning points from incidents, including those which occurred in other units within the hospital and Guy's Critical Care Unit (GCCU), frequently and via a range of methods. Learning points from clinical incidents were communicated to critical care staff directly via e-mail or text message as well as being displayed on communication screens in staff areas, which we saw evidence of during our inspection. The critical care multidisciplinary team also attended bimonthly half day clinical governance meetings for additional information and feedback.
- We saw evidence of learning from ECMO patients communicated throughout other centres who provided this specialist treatment, particularly in relation to the serious incident which occurred.
- 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.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety Thermometer and staffing details were displayed at the entrance to all critical care units other than the OIR and were entitled "Safe in Our Hands". Safety thermometer data detailed below covered the period August 2014 to July 2015.
- There were nine unit-acquired pressure ulcers reported within critical care; eight of these occurred on East Wing 1. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using the Waterlow Pressure Ulcer Prevention Score. There was a staff nurse identified as the tissue viability link nurse on most critical care units.
- Catheter care bundles were used throughout critical care and there had been no 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% across critical care between August 2014 and July 2015. Between August 2014 and July 2015 there were a total of 10 new VTEs within critical care, with seven of these occurring on East Wing 1.
- A recent ECMO audit was completed investigating the occurrence of deep vein thrombosis (DVT) after receiving ECMO. This showed a DVT was present in

20.5% of surviving ECMO patients and this was associated with longer periods of delays to administering prophylaxis. In response to this finding a check list was created for patients newly receiving ECMO which included ensuring DVT prophylaxis was started.

Cleanliness, infection control and hygiene

- Two housekeepers worked shifts to provide cover from 7am to 3pm on each intensive care area. HDUs shared a housekeeper, who also worked from 7am to 3pm, with the adjacent ward. The OIR shared a housekeeper with the theatres recovery area. For out of hours and for 'deep' cleans a rapid response team was available for all critical care areas 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 was used for ward areas. We observed this system in use throughout our inspection.
- Most critical care areas were seen to be clean, other than some pieces of equipment and high level surfaces such as shelves on Doulton HDU, which were covered in a layer of dust. We noted the poorest cleaning monitoring audit results across critical care in June 2015 were also found on Doulton HDU (93.02% compliance). Action points had been identified as a result of this audit, including recommendations for damp dusting of high level surfaces, however we found this issue continued to be a problem.
- We saw green 'I am clean' stickers were used on throughout critical care 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.
- On East Wing 1, we saw two mouse traps in place in the ward area and a mouse in the doctors' office. We raised this issue with the ward matron who assured us additional assistance from a pest control provider would be sought. During our unannounced inspection we saw evidence that additional measures had been implemented to address this problem including further involvement from pest control, more frequent cleaning in problematic areas and a ban of food within the doctors' office.
- There was an allocated lead consultant for infection prevention and control (IPC). 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.
- Alongside the trust-wide Infection Prevention and Control policy, we saw a critical care side room priority guideline was in place across the service which gave a list of conditions where isolation in a side room was essential, strongly advised, recommended if possible or unnecessary. We noted several patients being barrier nursed with isolation notices outside of side rooms, in line with the trust policy.
- During our inspection there were two barrier nursed patients in opposite corners of Page HDU with isolation signs in place. Staff told us this had been approved by the IPC team and patients were being nursed on a one to one basis to mitigate the risk of cross contamination. However we were concerned the HDU environment was not suitable for cohorting barrier nursed patients with non-barrier nursed patients in this way due to the close proximity of patients to one another, and insufficient clinical waste disposal and hand washing facilities.
- We observed most staff wearing PPE such as gloves and gowns during patient contact in accordance with the trust IPC policy, however we observed a ward round on Doulton HDU where no PPE was used by doctors during patient assessments. 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 were 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.
- Intensive Care National Audit and Research Centre (ICNARC) and hospital data showed the rate of unit-acquired blood infections was slightly worse than in other similar units. There were nine line related bloodstream infections 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, audits were regularly completed on East Wing 1, East Wing 2, and Victoria HDU to assess correct insertion

procedure and continuing care of intravenous lines and central venous catheters. Compliance with best practice was usually between 90% and 100%, however there were some occasions where scores were as low as 66% (Victoria HDU central venous line insertion in August 2015). Staff told us feedback was provided to individual staff directly and common errors were highlighted to staff across the department.

- Patients were swabbed for methicillin-resistant staphylococcus aureusis (MRSA) and gram negative bacteria on admission. ICNARC data showed no concerns relating to unit-acquired MRSA rates and performance in this area was generally better than in other similar units.
- Data provided by ICNARC showed a higher incidence of unit-acquired Clostridium difficile (C. difficile) than in other similar units, however this trend was improving.
- We observed staff throughout critical care following hand hygiene protocols, including washing their hands with soap and water and using alcohol gel. Hand hygiene audit results from August 2015 showed 100% compliance on East Wing 1 and East Wing 2 (up from 80% and 90% respectively).

Environment and equipment

- Critical care was provided across six different units in the hospital. East Wing 1 and East Wing 2 cared for level three patients and could accommodate 15 patients each, including five isolation beds in East Wing 1 and one isolation bed in East Wing 2. OIR cared for up to 11 short stay level three or level two patients, with no access to isolation facilities. Doulton HDU (10 beds), Victoria HDU (usually 10 beds including one isolation bed, but only six in total at the time of our inspection) and Page HDU (four beds) cared for level two patients before they were stepped down to the ward.
- Patient bed spaces were notably smaller than current critical care environmental recommendations which could place patients at risk of cross contamination. Additionally, not all isolation rooms had lobbies and there was limited availability of negative or positive pressure ventilated isolation rooms.
- Hand washing facilities and alcohol gel were available at the entrance to all critical care areas and we saw signs in place requesting visitors to clean their hands before entering. Alcohol gel was available within each critical care bed space.
- In most critical care areas there were adequate hand washing facilities, however we noted there were no hand washing facilities within the dirty utility room on one side of East Wing 2 ICU. This meant staff had to go through two doors and back into the ward area to be able to wash their hands after disposing of waste in the room which was not good hand hygiene practice.
- A full range of PPE was readily available in most critical care areas, however we noted large gloves were the only item of PPE available at the entrance to Page HDU during our inspection which was concerning due to the presence of two barrier nursed patients at the time. PPE were located on the window sills of Page HDU, however this meant staff had to move through the unit to reach them.
- In some critical care areas clinical waste bins were not readily available for each bed space, for example the main ward in Doulton HDU had a waste bin at the ward entrance and by the nursing station only and Page HDU had a clinical waste bin only at the bay entrance, despite having two barrier nursed patients within the bay. Bins were seen to be emptied regularly and none across critical care were noted as being overfull during our inspection.
- Dirty utility rooms were available on all critical care units, other than Page HDU which shared dirty utility facilities with the wards on which it was based. On inspection facilities and commodes within the dirty utility rooms were clean. There were two macerators which were labelled as being out of use (Page HDU and Doulton HDU); staff told us these issues had been reported and we saw evidence supporting this.
- Arterial blood gas analysers were available within East Wing 1, East Wing 2, Doulton HDU and Overnight Intensive Recovery, as well as at the entrance to Page HDU. Most machines were seen to be in use during our inspection and kept clean, other than the machine on Page HDU which had several old blood splatters on the plastic.
- Needle sharp bins were available throughout critical care including on emergency trolleys, with blood gas analyser machines and at patient bed spaces. Most sharp bins were seen to be correctly labelled and not overfull, other than the bin located at the blood gas analyser on Page HDU which was filled above the maximum fill line.
- A resuscitation trolley was available within or immediately outside each critical care area. Equipment

within the resuscitation trolleys was neatly stored and in date. We reviewed documentation which showed the frequency of checks completed on trolley equipment and found only occasional gaps in checking on Doulton HDU, East Wing 1, East Wing 2 and Victoria HDU.

- Difficult airway trolleys and a chest opening trolley were available on both intensive care areas and on Doulton HDU. Equipment within these trolleys was seen to be in date and neatly stored. Documentation showed twice daily checks were completed consistently.
- Consumables across critical care were kept in electronic storage unit which were accessed via a username and fingerprint log in. 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 efficiently.
- Medical equipment on the wards was maintained by the in house technicians from the biomedical engineering service and some by external contractors. We saw evidence that 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 was required to obtain permission for release of funds.
- Communication trolleys were available in East Wing 1 and East Wing 2 units which contained special equipment such as white boards and picture charts so staff could converse with patients with communication difficulties.

Medicines

- From 9am to 5:30pm Monday to Friday, there was a dedicated pharmacist for each critical care area with the exception of OIR and Page HDU which shared a pharmacist. This met current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. During the weekends, one pharmacist was available to cover all critical care areas including cross site at Guy's Critical Care Unit. The critical care pharmacy team was made up of eight ITU trained pharmacists.
- Electronic prescription charts were in place across critical care. We saw evidence patient allergies were recorded, medicine prescriptions were fully completed and any medicine omissions were noted. There were concerns regarding access to up to date patient prescriptions if the computer system failed and staff were required to print out paper versions of patient prescriptions every 24 hours in case this occurred. This was recorded as a concern on the risk register.
- Antibiotics were prescribed according to local policies which were referenced to national guidance. Staff told us these were readily available on the critical care intranet. Doctors also referenced the British National Formulary, however we noted out of date editions were in use on two units.
- We saw evidence that medicines were checked by two members of staff and this was recorded on the computer system. Trust policy stated all medicines should be checked by two members of trust staff, however sometimes it was necessary for an agency worker to check the medicine due to availability of trust staff during shifts.
- 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.
- Medicines were stored in locked cupboards or a locked medicines fridge if required. All storage units were seen to be secured when not in use during our inspection.
- Controlled drugs (CDs) were correctly stored in lockable wall units. We saw authorised signatory lists were available on the wards and documentation showing CD stocks were checked twice per day. We observed nursing staff administering CDs and following correct procedure, including completing necessary documentation and checking the patient's identity.
- Oxygen had been prescribed for patients in most instances where appropriate and this was reviewed during medical ward rounds. All oxygen cylinders checked within critical care were seen to be in date. Most cylinders were stored correctly in racks; however some were observed freestanding on the floor in Doulton HDU and Victoria HDU which is incorrect storage.
- Between February and May 2015 there were 90 reported medication incidents across critical care. Common themes included delays to medicine administration, incorrect infusion rates administered and incorrect

dosage administered. Senior staff and ward staff knew which aspects of medicines management were considered to be issues and reminders were in place for correct checking and preparation procedures.

Records

- Patient records were documented electronically throughout critical care, including regular observations, assessments, nursing notes and medical notes. Computers were available at each bed space in East Wing 1, East Wing 2 and most HDUs to allow staff easy access to patient information.
- Daily care records were seen to be completed thoroughly throughout critical care, including information such as regular observations, fluid balance, food consumed and holistic information for example family interaction.
- We found patients on most critical care units had daily reviews from medical staff recorded on their electronic notes, however we noted three patients on Doulton HDU had no medical notes entered.
- Medicine prescriptions were also recorded electronically. 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.

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.
- Staff knowledge about safeguarding principles was variable across critical care and within each area. Some staff knew what types of concerns would trigger a safeguarding referral and how to go about this whereas other staff incorrectly described safeguarding as ensuring bed space curtains were closed when performing care tasks. One senior nurse we spoke with was aware of staff confusion relating to safeguarding and maintaining patient dignity.
- Compulsory safeguarding training had been completed by 99% of critical care staff across the trust.

Mandatory training

- Key aspects of mandatory training such as information governance and health and safety were undertaken as part of the induction process for new starters. Additional mandatory training such as infection prevention and medicines management were undertaken as e-learning modules and further classroom based sessions.
- Staff told us they were able to complete their mandatory training within working hours when they did not have a patient allocated to them or they would be given a designated shift during which their training was completed.
- Safeguarding training, which included DoLS and mental capacity principles, had been completed by 97% of intensive care staff including GCCU. The trust provided evidence which showed the uptake of training was 70% for critical care staff. However, during the inspection the inspector was allowed access to the online mandatory training records. The records showed there were 205 critical care staff working across the two sites and infection prevention and control training had been completed by all but 87 staff. This meant the uptake of training was 58%.
- Safeguarding training had been completed by 100% staff on Doulton HDU, Page HDU and Victoria HDU. Infection prevention training was up to date for 76% of Doulton HDU staff and 87% of Page HDU staff.
- Staff were positive about the mandatory training provided by the trust and a new staff described the mandatory training as “better than in other trusts”.

Assessing and responding to patient risk

- An allocated critical care consultant assumed the role of acute pathway lead. This consultant was responsible for monitoring the patient pathway from deterioration through to critical care admission and during discharge to the ward. This consultant worked closely with the critical care response team to review referrals and support of patients stepped down from critical care.
- Patients were evaluated using the Confusion Assessment Method for the ITU (CAM-ITU) flowchart to determine whether delirium was evident, in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We saw evidence this assessment was completed with appropriate patients during our inspection. Patients were referred to the Delirium and Dementia (DaD) team for additional support once delirium had been identified.

- AMBER care bundles were used in the HDU areas for deteriorating patients with an uncertain outcome. These care bundles helped guide care provided and highlighted when review by medical staff was required.
- 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 critical care.
- Staff told us the medical and nursing teams would discuss which patients were most suitable to be transferred to OIR if the intensive care wards were approaching full capacity. They said this meant the patient who would be at least risk from the transfer would be identified and moved if required.
- For patients 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 acute response team would be responsible for assessing the patient. The acute response team was staffed by a site nurse practitioner and was not managed by the perioperative, critical care and pain directorate.
- 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 80%.

Nursing staffing

- Nursing staff levels on all critical care units including cross-site at GCCU was overseen by one of the critical care matrons who held a specific bleep for this purpose from 8am to 6pm Monday to Friday. Outside of these hours, management of nursing staffing was the responsibility of the shift coordinator on East Wing 2 ITU who would carry the matron's bleep. We were told staffing was assessed across critical care as a whole and staff were moved between units to accommodate the needs of patients and ensure safe staffing levels. During our inspection, we saw evidence of staff being redeployed to other areas of critical care to support this.
- Staff told us all critical care units had a supernumerary shift coordinator or shift manager on duty at all times who had completed specific training and competencies for this responsibility. We saw rotas and competencies in place supporting this and observed supernumerary staff in place during our inspection. Staff told us it was rare for the supernumerary management staff to take responsibility for a patient as there was nearly always enough nurses on duty.
- 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. Patient allocation records demonstrated critical care complied with the required staffing levels and we saw evidence of patients with additional care needs, such as those receiving ECMO, being cared for by two allocated nurses. However one senior member of staff told us this record would not be updated throughout the shift which meant changes to patient acuity or new admissions might alter the staffing ratios, particularly in OIR.
- Staff worked shifts from 7:30am to 8pm and night shifts from 7:30pm to 8am, with nursing handovers taking place at the start of each shift. On East Wing 1 and East Wing 2, nursing staff received a general overview of patients on the unit and completed a nursing safety briefing, which included important information such as identifying patients at risk and any significant incidents which had occurred during the previous shift. Staff then completed a comprehensive 'patient specific' bedside handover at the start of their shift. HDU staff followed a similar procedure but no formal safety briefing was used as this had not yet been rolled out to all critical care areas.
- Nursing staff rotas demonstrated little use of agency staff and none of the staff we spoke with on critical care during our inspection were from an agency. Senior staff told us they usually used their own staff on bank shifts rather than agency workers and records we reviewed supported this.
- Staffing details displayed during the course of our inspection showed most units were fully staffed during day and night shifts. Doulton HDU appeared to be one nurse short overnight but the nurse in charge was able to demonstrate safe staffing levels could be achieved with the number of nurses they had available.

- Results from a workforce mapping exercise in May 2015, completed in conjunction with the South London Adult Critical Care Network, showed band five critical care vacancies 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.
- New staff completed a period of supernumerary working and were allocated a mentor to support them during an induction period. There were specific competencies in place which had to be signed off before the staff member was able to work independently.
- The critical care response team worked from 8am to 8pm and was staffed by two or three band seven ITU nurses. A senior outreach nurse was in charge of the team and provided support when required.

Medical staffing

- There were 24 intensive care consultants who participated in the rota covering the critical care units in the hospital and cross-site at Guy's Critical Care Unit. The provision of consultants met the recommended consultant to patient ratio.
- Results from a workforce mapping exercise in May 2015, completed in conjunction with the South London Adult Critical Care Network, showed consultant vacancies were in line with other adult critical care unit (12.8% compared with 12% in other units).
- There was an allocated consultant to cover East Wing 1 ITU, separate consultants for the early and late shifts on East Wing 2 ITU and a consultant allocated to Victoria HDU. There was a separate consultant allocated to manage patients receiving ECMO. Trust policy was that Page and Doulton HDUs were overseen by a dedicated consultant intensivist and responsible surgical team e.g. cardiovascular/cardiothoracic teams respectively. However, this was inconsistent with what we were told during the inspection. We were told that Page and Doulton HDUs were overseen by surgical consultants, consultant ward rounds rarely took place and the registrar led patient care in these areas.
- Patients on OIR were primarily managed by the theatres anaesthetic team but could be reviewed by the intensivist allocated to East Wing 1 ITU if there were concerns about their condition.
- The consultants usually covered their allocated unit for a period of three days (Monday to Wednesday) or four days (Thursday to Sunday), which was compliant with best practice guidance for continuity of care. There were some periods when consultants covered a unit for seven days in a row. Anaesthetic consultants covering OIR usually covered the unit for 24 hours at a time which was not compliant with continuity of care guidance as many patients stayed on this unit for two days or more.
- Consultants worked shifts from 8:30am to 9:30pm and were supported by a number of specialist trainee (ST) grade and junior doctors. On East Wing 1 and East Wing 2 ITUs, there were between two and four ST or junior doctors supporting the consultant on shift at any one time. The Victoria HDU consultant was supported by one ST grade and one or two junior doctors. Support for the ECMO consultant was provided by one ST grade doctor. The provision of ST and junior doctor support met the recommended doctor to patient ratio.
- Results from a workforce mapping exercise in May 2015, completed in conjunction with the South London Adult Critical Care Network, showed there were more junior doctor vacancies (35.3% compared with 14%) and more ST grade doctor vacancies (18.8% compared with 13.9%) than in other adult critical care units within the network. Despite this, rotas we reviewed and during our inspection we observed wards were staffed by a full complement of supporting doctors.
- There was an allocated consultant lead who was responsible for managing the needs of junior doctors, for example ensuring rotas complied with the European Working Time Directive, adequate study leave was provided and mandatory training was completed.
- Medical handover meetings took place at 8:30am and 8:30pm, where the doctors on duty would handover patient details and any relevant updates to the medical staff coming on shift. Staff told us a critical care daily safety briefing form was reviewed during every medical handover and included safety items such as identifying procedures planned for the day, any patients with similar names and patient allergies. We observed this comprehensive safety briefing in use during a medical handover, where safety issues were appropriately raised and discussed by the team.
- Following the handover, consultants on East Wing 1 and East Wing 2 completed a unit "walk around" where nursing staff caring for specific patients could raise any concerns for their immediate attention prior to the full

bedside ward round, which took place from 9:15am. There was an additional ward round completed from approximately 5pm each day, which was compliant with recommendations from the 'Faculty of Intensive Care Medicine Core Standards for Intensive Care Units'.

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.
- In preparation for an Ebola or Middle East respiratory syndrome (MERS) outbreak, several steps were implemented to prepare staff. Ventilator hood training was in place and two weekly PPE training sessions were taking place for volunteer staff. Additionally, there were plans to recruit a lead consultant for PPE to manage this aspect of preparation.
- A simulation exercise for a patient on the Ebola pathway was completed in October 2014, starting in the emergency department and progressing through the hospital to critical care. A number of process improvements, such as improving the readiness of a critical care area for receiving this type of patient, were recommended as a result of the simulation and these adjustments had been implemented at the time of our inspection. However, there had been no further simulation to test the changes which had been introduced.

Are critical care services effective?

Good

Critical care provided an effective service. Patient outcomes including mortality were generally good and outcomes for patients receiving ECMO were better than the national average. Patients were cared for by competent medical staff following evidence based policies and care bundles. Patients were regularly assessed for pain and their analgesia was reviewed on a daily basis.

Multidisciplinary working process were embedded and access to physiotherapy and diagnostic imaging was good. Staff could readily access important information and were aware of the need to obtain consent, taking into account mental capacity principles. However staff knowledge of Deprivation of Liberty Safeguards was not consistent and many were unsure how this was applicable to the critical care setting.

Nursing staff were initially supernumerary when starting work within critical care and completed competencies before being able to work independently. However insufficient numbers of critical care nursing staff had additional critical care training and appraisal rates were low. Availability of dieticians, occupational therapists and speech and language therapists was limited.

Evidence-based care and treatment

- Policies and procedures were available on the critical care intranet and trust intranet. There was an allocated staff member who was responsible for ensuring critical care policies were kept up to date and uploaded onto the intranet accordingly. We checked the review date of 113 policies on the critical care intranet and found 30 were beyond the date of review specified.
- Evidence based guidance was in place for assessing patients in severe respiratory failure and for managing patients receiving ECMO.
- Ventilator-associated Pneumonia (VAP) care bundles were in use on East Wing 1 and East Wing 2 in line with best practice guidance. During the Intensive Care Infection Control Meeting in July 2015, the care bundle was updated to remove the chlorhexidine gel and mouthwash in response to most recent research findings. Hospital audit data between August 2014 and July 2015 showed variable compliance with VAP care bundles; on East Wing 1 compliance varied between 75% and 100% and on East Wing 2 compliance was between 66.7% and 100%.
- An Intubation Checklist was in place to ensure patient intubations on East Wing 1 and East Wing 2 occurred smoothly. The checklist involved organising the correct equipment, preparing the patient appropriately as well as allocating roles to the team and this was based upon national guidance.

Pain relief

- Pain was assessed on an hourly basis as part of basic patient observations using a formal patient reported scoring system. This documented patient reported pain levels and which activities brought on the patient's pain.

Pain assessments for unconscious patients within East Wing 1, East Wing 2 and OIR were recorded according to patient response to interventions, such as grimacing when turned.
- Support for patients with pain issues could be obtained from the hospital pain team who were available via a bleep system 24 hours per day.
- Patient controlled analgesia (PCA) could be managed on all critical care units by nurses with specific training and patients with epidural pain relief in place could be cared for in either East Wing 1 or East Wing 2.

Nutrition and hydration

- There were two whole time equivalent (WTE) dieticians allocated to critical care; this was not compliant with British Dietetic Association recommendations which suggested between three and four WTE dieticians for the number of beds covered.
- Patients on East 1 and East 2 ICUs were reviewed by an ICU trained dietician from Monday to Friday. Outside of this time, nursing staff were responsible for initiating enteral feeding if required. Staff highlighted the critical care enteral feeding policy on the intranet and explained how they would calculate feed doses from this policy.
- Patients known to require total parenteral nutrition post procedure (Such as oesophagectomy) would have this organised by the dietician prior to the operation so there was no delay in initiating nutrition.
- Patients who were able to eat and drink had a choice of food from a menu, which included vegetarian, gluten free, halal, 'easy to eat' and pureed options. We noted checks were in place to ensure food was served at an appropriate temperature and this was documented.
- We saw suitable patients were provided with jugs of water and were offered hot drinks, as well as snacks throughout the day. Staff ensured drinks were provided in easy to hold containers and offered patients straws if they had difficulty drinking out of a cup. Drinks were seen to be within patient reach throughout our inspection.
- We observed fluid monitoring recorded on the electronic patient records and staff told us it would always be highlighted during handovers if a patient was on a fluid restriction.

Patient outcomes

- The critical care service 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. ICNARC data quoted relates to East Wing 1 and East Wing 2 as well as Victoria HDU and covers the period from April 2014 to March 2015. Staff told us from April 2015 data had also been submitted to ICNARC relating to Doulton HDU, Page HDU and OIR to allow performance analysis and benchmarking for these additional units, however this information was not available at the time of our inspection.
- ICNARC data showed the critical care mortality was 14% and the mortality ratio was 0.91, which was better than other similar units. The rate of post critical care hospital deaths was generally in line with similar units.
- The mean length of stay on critical care reported by ICNARC was 6.8 days which was longer than in comparable critical care units. The hospital target average length of stay on critical care was 8 days and audit data from August 2014 to July 2015 showed this target was met in seven 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 units between August 2014 and July 2015.
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated there were fewer patients discharged from critical care 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 slightly worse than in other similar units. Hospital audit data between August 2014 and July 2015 demonstrated ICU readmissions were usually lower than the 1.3% target set by the hospital, however in 11 months readmissions to Victoria HDU were higher than this target (Up to 7.7%).
- Data provided by ICNARC showed readmission to critical care after 48 hours occurred more frequently than in other similar units.

- 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 critical care left hospital with the same or better independence they were admitted with.
- A total of 134 patients received VV (respiratory supporting) ECMO in East Wing 1 between August 2014 and July 2015. Of these patients, 77% survived the ECMO period and 71% survived to hospital discharge or transfer. The Extracorporeal Life Support Organization (ECLSO) registry report from July 2015 demonstrated these statistics were better than average outcomes, as 66% of patients survived ECMO nationally and 58% reached discharge or transfer.
- A total of four patients received VA (cardiac supporting) ECMO in East Wing 1 between August 2015 and July 2015. A total of 80% survived the period receiving ECMO and reached hospital discharge or transfer. Although this data represented a small number of patients these outcomes were better than the national average identified by ECLSO; 56% survived the ECMO period and 42% reached hospital discharge or transfer nationally.

Competent staff

Nursing Staff:

- All new nurses working in critical care were allocated a period of supernumerary practice, during which they were expected to complete a series of competencies which had to be signed off prior to independent working. We saw evidence these competencies were being completed by supernumerary members of staff. Staff we spoke with were clear these competencies should be signed off once the skill had been consistently demonstrated, rather than just on a one off basis. Staff told us this ensured the skills were embedded. 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.
- New starters were provided with "A Brief Guide to being a Critical Care Nurse" information booklet which provided information about the unit, expectations of the role and an overview of the basic care needs of critical care patients. Nurses who had recently started told us this booklet had been very useful when they first started in the role.
- Staff completed specific competencies to be able to assume the role of shift coordinator. These competencies involved aspects such as communication, people management and quality. Staff were also able to spend one shift observing the shift coordinator as a supernumerary member of staff to facilitate their learning. Nurses we spoke with who were working towards these competencies told us they were being allowed plenty of time to develop the necessary skills before assuming the shift coordinator role and we saw evidence of competency sign off.
- Staff rotated on a staggered eight monthly basis between the two ITU units on site and Guy's Critical Care Unit. Senior staff told us this was to allow additional development opportunities for nurses. There were plans in place to commence staff rotations between OIR and Doulton HDU starting from October 2015.
- Each critical care unit had a dedicated Clinical Nurse Educator who was responsible for all elements of training and education for the nurses on that unit as well as supporting student placements.
- 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 critical care, an average of 40% of nursing staff had an additional critical care nursing award. On East Wing 1 and East Wing 2, 46% of nursing staff had an additional qualification. On Victoria HDU, Doulton HDU and Page HDU 34%, 46% and 53% of nursing staff had completed an additional qualification respectively. In OIR, 63% of nursing staff had completed further training.
- Allocated link nurses were in place for a number of key themes within each critical care area such as tissue viability, infection control and patient experience. This allocation meant nurses on the units could seek guidance from their colleagues around specific issues. Staff told us this system worked well and they felt they asked for guidance more readily rather than contacting the specific teams within the hospital.
- A specific two day simulation course was in place to train nursing staff in managing patients receiving ECMO and the ECMO equipment. We reviewed the comprehensive course programme and received

feedback from attendees who were positive about the training. In addition to attending the course, staff had to complete an ECMO specific competency document. There were additional monthly updates covering topics such as a perfusion update for ECMO trained staff to maintain competence and up to date knowledge.

- 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, 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.
- Appraisals had been completed within the previous 12 months for 47% of staff in intensive care, 53% of staff on Doulton HDU, 60% of staff on Page HDU and 56% of staff on Victoria HDU. Staff told us their appraisals were a two-way process and a useful exercise but it could be difficult to book time in with the right person for this to be completed.

Medical Staff

- We saw evidence showing 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.
- There was a weekly training session for junior doctor covering 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.
- 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

- Therapy-themed multidisciplinary team handovers took place every Wednesday on East Wing 1 and East Wing 2. During these handovers, therapists updated the rest of the team about patient rehabilitation progress and goals.
- Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator weaning programmes (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own).
- Therapists worked closely with ward staff in liaising rehabilitation around other plans, such as investigations and ventilator weaning. We observed nursing staff and therapists working together to complete patient care tasks and rehabilitation.
- Specific discharge summaries for ECMO patients were sent directly to their GP on discharge from critical care. This system was set up due to concerns from ECMO consultants about insufficient information about the ECMO intervention received by the patient reaching the GP in the standard hospital discharge summary.

Seven-day services

- 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, the acute response team was available which was not part of the critical care directorate.
- Diagnostic imaging services were obtained via an electronic referral process. Staff told us imaging normal working hours were from 9am to 5:30pm but an on call service was available outside of this time. Staff told us all imaging within the hospital was completed according to clinical need and told there were very rarely delays to investigation for critical care patients.
- Physiotherapy was provided by a team of 11 staff, with six staff members working 8:30am to 8pm Monday to Friday. Weekend cover was provided by three therapists. The team provided a full respiratory and rehabilitation service throughout the week, including an on call respiratory service out of hours.
- Speech and language therapy (SALT) was 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 "rarely seen" in critical care. Referrals were made via computer-based system and had a typical response time of three working

days. Staff told us the physiotherapists led rehabilitation on critical care and would usually make the referral to OT if needed. Staff said OTs were usually used to access splints for critical care patients.

Access to information

- Patient admission details, including past medical history, operation notes and a social history, were recorded on the electronic patient record. Paper medical notes were available for some patients depending upon the admission pathway. Electronic records could be accessed via a staff log in on any computer which had the relevant software installed. This meant staff could access the information from anywhere within the hospital and we were told this was useful when discussing individual patient cases away from the ward area.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically and could be directly uploaded to the patient's record. Arterial blood gas results were automatically save to the patient's record when analysed by the gas machine.
- Critical care units, other than Page HDU, had folders entitled "How to Help Your Patient" which contained information about support and services available within the hospital for patients as well as external organisations who could provide assistance. We observed staff using these folders to obtain information for patients during our inspection.
- On Doulton HDU the patient name board used a traffic light system to note whether patients had been or needed assessing for VTE risk, seeing by pharmacy, physiotherapy, dietician and speech and language therapy. This allowed staff to identify patient MDT needs quickly.

Consent, Mental Capacity Act and DoLS

- Staff told us it was necessary to obtain consent from patients before performing care tasks, investigations or giving medicines. Where consent could not be obtained, for example unconscious patients, staff explained care would be provided in the patient's best interests. We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind the procedure being performed.
- There was a specific form for documenting mental capacity assessments on the electronic patient records. Staff were able to locate this form quickly and showed us evidence where this assessment had been completed.
- Staff knowledge of DoLS was variable across critical care. Some staff were able to fully describe principles behind DoLS but were unclear how this was applicable to the critical care setting, whereas others told us they had never heard of DoLS. Staff within OIR provided a recent example where DoLS had been implemented appropriately and a restrictive interventional procedure was approved for a patient who was delirious, agitated and aggressive.
- Senior staff told us application of DoLS within critical care had not been formally recorded in a policy and so it was not explicit what steps should be taken and which paperwork should be used for this.

Are critical care services caring?

Good

Care provided within critical care was good. Patients were positive about care across the service and this was reflected in the patient feedback survey results, particularly from patients who received ECMO and their families.

Patients told us their privacy and dignity was maintained at all times and staff gave full explanations when providing information, allowing patients and relatives to ask questions. Staff took time to get to know patients and we observed staff taking an interest in patient lives outside of the hospital, including creating photo boards of the patient's friends and pets. Patient diaries were used for many patients and contributions from staff and visitors were evident.

Relatives were involved in patient care and staff held meetings with relatives when requested or when they felt it was needed. Staff provided emotional support to patients and relatives alike and could signpost to services within the hospital as well as external organisations for additional support. Memorial services were held to remember those patients who died in critical care.

Compassionate care

- Patient satisfaction questionnaires were used on the high dependency units and we saw evidence of results from Victoria HDU and Page HDU in July and August 2015. Results from both wards were positive, with many positive comments such as "everything first class" on Victoria HDU and "five star treatment" on Page HDU.
- Family satisfaction surveys were sent out to the relatives of all patients discharged from ICU 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.
- Satisfaction surveys were provided retrospectively to ECMO patients and their families. We reviewed results from surveys received between January and December 2014 which were overwhelmingly positive about the nursing and medical staff involved.
- We observed staff chatting with patients and asking them questions about their families and interests. Patients told us staff made an effort to get to know them and to make them feel comfortable.
- Patients throughout critical care told us staff maintained their privacy and dignity at all times by keeping them "covered up" and drawing the curtains for washes. We observed staff across critical care ensure patient dignity was preserved at all times, such as taking extra care to ensure the curtains were fully closed around the patient bed space.
- Red pegs were consistently used throughout critical care to indicate personal care or a procedure was taking place and we observed staff ask permission before attempting to enter.
- Relatives were confident in the care provided by the critical care service and told us "nothing could be done better". They believed the patients were "safe and well cared for by amazing staff".
- On more than one occasion we observed a physiotherapist encouraging patients with their rehabilitation in a supportive and positive way. One patient told us the therapy teams had kept his "positive attitude going".
- During our inspection we saw a patient bed space had been decorated with celebratory banners. We were told staff had helped the patient's family with the decorations and had participated in celebrating the patient's birthday.
- We noted many thank you cards and letters received from patients praising the care they had received throughout critical care. A significant proportion of cards and letters were related to the ECMO service.

Understanding and involvement of patients and those close to them

- Patients told us staff provided thorough explanations about what had happened to them and what the on-going care plan was. Patients felt they were given opportunities to ask questions and these were answered thoroughly and patiently by staff.
- We observed staff interacting with patients and involving them in decisions about their care, for example one patient discussed dietary requirements with a member staff and came to a joint decision that supplement drinks would be a sensible plan.
- Staff introduced themselves and their role to patients throughout critical care. Patients told us this was needed because it could be difficult to tell who was who due to all staff wearing the same colour theatre scrub uniforms on critical care.
- Relatives told us they were included in the care of their loved one, including assisting with care tasks when appropriate and rehabilitation. One relative told us they had been taught how to complete specific stretches with the patient which had made them feel useful and like they had helped.
- We saw several patients on critical care with white boards within their bed space which were covered in photographs of their relatives, friends and pets as well as cards and letters. We observed one nurses chatting to the patient about where the latest card received should go on the whiteboard.
- Patient diaries were started for patients ventilated for 72 hours or more and all patients receiving ECMO. All members of the MDT as well as the patient's relatives and friends were encouraged to write in the diary.
- Staff told us they sometimes held meetings for families with relatives on critical care so that any questions about their relative's time in hospital could be

answered. We saw evidence of minutes from these meetings, including a meeting with a family whose relative passed away on the unit and a discussion about ceilings of intervention for another patient.
- An audit reviewed how many discussions with patients' families took place within 72 hours of admission to critical care between July 2014 and June 2015. The information showed approximately 70% of family discussions took place within 72 hours on East Wing 1; however this showed a worsening trend over the last three sets of data, and approximately 65% on East Wing 2, with an improving trend.

Emotional support

- During our inspection, a patient passed away on one of the HDUs and we observed staff taking time to check other patients had not been unduly upset by this. Staff were also seen offering kind words and support to the bereaved family, who were able to stay with their loved one until they were ready to leave.
- 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. The memorial service was made up of readings, hymns and prayers as well as an address from a senior critical care consultant. Staff told us this service was valued by relatives and they often saw the same relatives attend year after year. There were approximately 150 attendees to this service in December 2014.
- A multi-faith spiritual team were available to provide support within the hospital 24 hours per day.
- Critical care staff offered to direct patients and relatives to external support organisations and relatives told us they felt as though staff had provided them with information they needed to "look after" themselves.

Are critical care services responsive?

Good

Critical care was responsive and people's needs were met through the way the service was organised and delivered. A flexible service was in place with a "never say no" admissions policy for all patients requiring critical care and priority was given to patients with the most urgent needs. Flexible visiting was available across critical care and facilities including accommodation for relatives were generally good. Information for patients and relatives including how to make complaints was readily available across this service.

Some patients experienced delayed discharges from critical care however this was better than in similar units and few were transferred out of hours. Difficulties with access to level two beds were being addressed and knock on effects of high critical care capacity levels including overspill into the theatres recovery area were being managed to minimise disruption to other services.

Service planning and delivery to meet the needs of local people

- Critical care served a combination of specialities, including postoperative patients and medical patients. Staff told us this could make service planning difficult as it could be hard to predict patient need at any one time; some patients had critical care beds booked post procedure and others were admitted directly from the emergency department or the medical wards after becoming significantly unwell.
- Staff told us it was rare for elective procedures to be cancelled due to a lack of critical care or recovery beds but explained decisions would be made amongst the surgeons, anaesthetists and critical care consultants if this was the case. Between May and July 2015 there were five procedures cancelled due to lack of critical care bed availability, which accounted for 0.7% of all surgical cancellations.
- Service delivery was managed through a responsive critical care service which flexed bed numbers, staffing and patient distribution to respond to patient needs. For example, OIR was intended to care for 11 level two or level three postoperative patients for up to 24 hours post procedure. Staff told us this area was commonly used as an intensive care "overspill" area, and extended beyond the 11 allocated beds into the theatres recovery area on a weekly basis. During our inspection, we observed three critical care patients in the theatres recovery area at one time. Additionally, the six bedded Victoria HDU could have a further four beds opened in response to bed pressures. During our inspection, the additional three bedded bay was being prepared for

opening and was in use during our unannounced inspection. The remaining side room continued to be closed and staff told us this would be opened at a later date when needed.
- Limitations relating to critical care bed availability were being addressed in the short term via the development of a new 20 bedded HDU and in the long term in the form of a substantial critical care redevelopment project.
- Staffing for the flexible service was managed by a designated matron who was responsible for coordinating staffing across the entire critical care service, including Guy's Critical Care Unit. Staff we spoke with were able to demonstrate how safe staffing levels had been maintained despite this flexible approach to service provision.
- 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.

Meeting people's individual needs

- There was open visiting on East Wing 1 and East Wing 2 to allow flexibility for visiting relatives. Doulton HDU, Victoria HDU and Page HDU permitted visiting between 2pm and 8pm. OIR allowed visiting between 3pm and 7pm. Staff across all HDU areas told us there was flexibility with visiting times if needed and one staff member provided an example of a relative who worked shift patterns and this was accommodated by altering the visiting times for that patient. All visiting was limited to two visitors per bed space at any one time.
- Questionnaires called "tell us about your loved one" were given to relatives so information about patient preferences could be identified early on in their admission. This leaflet requested information such as preferred name, communication needs, mobility details, their interests and personal care details. We saw these leaflets had been completed and nursing staff referred to the information obtained from them during our inspection.
- Information leaflets entitled "Critical care at Guy's and St Thomas'" were available within the waiting areas of East Wing 1 and East Wing 2. These leaflets contained information for relatives about what to expect within the critical care environment.
- 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 who did not speak English as their first language. Staff could access interpreters via the telephone or make bookings for interpreters to attend face to face meetings.
- Psychiatric support could be provided by the hospital psychology team following a computerise referral by a member of the nursing or medical teams. Staff told us support from the team could be obtained quickly if needed.
- Waiting facilities for relatives visiting patients in critical care were variable according to which unit they were visiting. East Wing 1 had two rooms available and drink making facilities available for visitors whereas OIR had no designated relative seating area and relatives were seated on a bench in a corridor when waiting.
- Most critical areas had access to quiet rooms or offices where difficult or confidential conversations could be held with relatives. OIR had no area available for this purpose, although staff told us it was sometimes possible to use the theatres meeting room if it was free.
- Accommodation could be provided for relatives who lived a significant distance away or who had difficulties accessing the hospital while patients were admitted. Staff told us relatives could have three nights free accommodation and then a small charge was made for on-going accommodation. Additionally, three days free parking was provided for families whose loved ones were admitted to critical care.
- Family care packs containing snacks and bottled drinks were available for relatives of patients who were approaching end of life. Staff told us this meant families did not need to leave their loved one during their last few hours.
- Patients who stayed in East Wing 1 or East Wing 2 for more than seven days and who were ventilated for more than five days were invited to attend a three month intensive care follow up clinic. This clinic was provided by a multidisciplinary team including a physiotherapist, dietician, nurse and psychologist. This clinic was started in April 2015 and had seen 12 patients in total. Staff told us there were plans to evaluate the patient response to the follow up clinic but these were not in place at the time of our inspection.

Critical care

Access and flow

- No critical care admissions policy was in place and senior staff told us they had never been able to produce a policy which thoroughly covered all eventualities. Several senior staff described the "never say no" approach regarding critical care admissions in the hospital; they told us everyone who needed to access critical care could access it in the hospital. This was also the case with accepting critical care transfers from other centres. Senior staff described flexibilities, such as using OIR for intensive care patients and opening additional level two beds, within the critical care service which had enabled this admissions approach to be successful.
- Referral guidelines were in place for patients being considered for ECMO treatment. These guidelines included specific clinical specifications such as levels of oxygen in the bloodstream and ventilation requirements.
- Priority for critical care beds was given to those with the greatest urgency, for example patients receiving ECMO would be admitted to East Wing 1 and a level three patient would be cared for in OIR instead once this had been risk assessed by the medical team.
- Patients admitted to intensive care were reviewed by an intensive care consultant as part of the 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 was consistently above the national average between April 2014 and March 2015.
- ICNARC data showed delays between decision to discharge patients from critical care and actual discharge affected approximately 40% of patients. Delays between four and 24 hours affected 38% of patients and 2% experienced delays of greater than 24 hours. ICNARC data showed these delays were better than in other similar units. Staff told us delays were generally due to the lack of available ward beds.
- Staff described difficulties associated with stepping down intensive care patients to the HDU environment due to insufficient numbers of level two beds within the hospital and told us patients were sometimes discharged to the ward rather than HDU from intensive care.
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated there were fewer patients discharged from critical care 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.

Learning from complaints and concerns

- Most of the relatives waiting areas within critical care had posters and leaflets advertising the services of the Patient Advice and Liaison Service (PALS) and information about how to complain. Relatives we spoke with were aware they could raise any issues with staff on the ward or seek assistance from PALS if needed.
- Complaints were received by the critical care matrons via the PALS, critical care administration and informally from ward staff. Staff told us complaints were investigated by the lead clinician for clinical governance before being fed back to the ward staff.
- Between September 2014 and August 2015, there were three formal complaints received by the critical care service. A common theme from informal complaints received was the amount of noise within critical care areas at night. In response to this, a 'Noise at Night' checklist was introduced to each area which was referred to throughout the nightshift, ensuring noise levels are kept to a minimum for example by reducing the volume on patient alarms. Staff told us the number of comments about noise levels at night had reduced but some were still received.

Are critical care services well-led?

Good

Leadership across critical care services was good and promoted the delivery of high quality care. The vision for service development was communicated to staff, quality focused and clear. Effective governance processes were in place across the critical care service and ward staff received timely feedback when necessary. Risks identified by the service matched our inspections findings and plans to address risks were in progress, such as developing the new HDU area.

Staff and patients were engaged by senior staff in offering ideas and providing feedback, for example with the new building plans. We found evidence of significant contributions to national and international research

projects as well as implementation of innovative practice such as telemedicine. Cost improvements were made by way of streamlining ward practice and improving procurement processes, ensuring no detriment to quality of service provision.

Vision and strategy for this service

- Senior staff identified the management of HDU areas as a strategic challenge within the hospital. Doulton HDU and Page HDU were recently adopted by the directorate and so management of these units had also been transferred. Staff on these wards told us there had been a palpable improvement in the way the units functioned following the change in management. Obstetric HDU and the vascular acute care bay offered level two care but were not managed under the critical care directorate. Senior staff told us they hoped to pick up these units to make level two care within the hospital "seamless".
- 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 the hospital to address the expected shortfall of critical care beds. At the time of our inspection, a business case including detailed plans of the proposed unit was in the process of being created. Staff were aware of development plans and told us it was hoped building would commence in early 2017.
- It was acknowledged by staff at all levels that facilities within several of the critical care units were not optimal and this needed to be addressed as a priority before the major critical care rebuild in future years. We saw plans were in place to build a new 20-bedded HDU located in Albert ward, amalgamating Victoria HDU and Page HDU and adding an additional 10 HDU beds. It was hoped this new unit would be open by May 2016.The plans for the new HDU area were described by senior staff as "significantly better than what we're currently working with".
- Development of the severe respiratory failure service was a priority development area for senior critical care staff. Anticipation of increased use of ECMO meant staff aimed to increase capacity to six patients on ECMO at any one time and to further develop the provision of VA (cardiac supporting) ECMO for local patients with severe, acute and reversible heart failure or as a bridge to transplantation. Additionally, NICE guidance confined the use of external carbon dioxide removal devices to specialist centres only and plans were in place to trial a number of devices for this purpose.
- Ward staff knew how their work contributed to the wider vision of the trust and were aware of the trust values. Staff across critical care provided examples of how the service they provided reflected the trust values, for example in order to 'put patients first' one staff member told us the flexible admissions policy for critical care meant every patient who genuinely needed critical care support would receive it at the hospital.

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 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 for additional information. The critical care multidisciplinary team also attended bimonthly half day clinical governance meetings for additional 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. Nurses who had attended this meeting told us it was useful and helped provide rationale for changes to practice which had been enforced.
- Regular ECMO meetings were attended by the ECMO consultants and senior ECMO nurses. Minutes from these meetings demonstrated identification of training gaps, audit reviews and equipment discussions.
- An allocated consultant took the lead for patent safety, clinical risk and patient experience. This role involved promoting safety throughout clinical process, 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, for example the risk of patients contracting health care acquired infections. Two items on the register had been recorded as a risk since 2007, however there had been many updates regarding 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.

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 Guy's Critical Care Unit 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 working within critical care described the matrons and Head of Nursing as readily available and approachable. All staff were aware of which matron was responsible for the unit they worked on and knew how they could be contacted if needed. We noted these senior staff were visible on the wards throughout our inspection and knew ward staff across the service.
- A supernumerary charge nurse was allocated to each nursing shift to provide immediate leadership and facilitate service delivery on every critical care unit. Staff across critical care spoke positively about the ward charge nurses, praising their supportive attitudes and open approach to management.
- 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

- An open culture was encouraged on critical care and we saw evidence the new trust-wide 'Showing we care by Speaking Up' initiative had been communicated to staff via the monthly critical care newsletter and also on posters within staff areas. Staff told us they would feel comfortable raising any issues directly with critical care management but might consider using the 'Speaking Up' contact if it was a sensitive issue.
- Staff at all levels were proud of the service provided by the critical care units and were keen to tell us about good patient outcomes, research projects and other service developments which were in place.
- Staff had good working relationships with each other and told us there was a good dynamic across the department. Some staff chose to socialise outside of work and social events were organised for staff, such as the critical care summer party.
- Compliments and messages of thanks were communicated to staff via the newsletter, on communication boards and mentioned during staff meetings. Staff told us they knew when feedback was received from patients and their relatives.

- Critical care management valued the ward staff and were quick attribute the successes of the department to the staff working face to face with patients. One senior member of staff told us "nurses across critical care always perform beyond the expectations of management" and described their teamwork as "integral" to the performance of the service.

Public and staff engagement

- A patient and family experience work shop 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 to discuss key issues relating to critical care, for example visiting times and reducing delayed discharges.
- Details of the directorate's financial situation were communicated to staff via the monthly newsletter and also during team meetings. Staff on the ward were able to describe this to us and explained the link to how busy the unit had been.
- Development plans for the new 20-bedded HDU were given to ward staff for their feedback. Staff told us their comments were taken on board and they saw altered plans as a result of the feedback provided.
- Staff were asked to complete a survey prior to the pilot trials of telemedicine (remote patient monitoring) on critical care which were completed in August. Drop in sessions for staff were held by the project team to give as many staff as possible exposure to the telemedicine equipment and allow opportunities for feedback. Additionally, there were two whole day workshops where multidisciplinary staff helped to shape the operational processes for using telemedicine on critical care. Staff who attended these sessions told us they were excited about the introduction of telemedicine and enjoyed contributing to the development of the technology.
- 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 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 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 trialled telemedicine technology during August 2015. Senior staff told us of plans to roll out a larger trial period, involving higher patient numbers before introducing the technology on a broader level. It was hoped this type of patient monitoring would allow staff to identify trends in patient observations more quickly and therefore be able to respond in a shorter timescale. Senior staff described some difficulties with the larger scale roll out, such as staffing the monitors, and told us of plans to address these issues.
- Critical care recently introduced a text messaging service so key information can 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 are 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; simply 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). Changes to practice were made in response to research findings, for example updating the VAP care bundle to remove the chlorhexidine mouthwash.

- 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.

Maternity and gynaecology

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

Information about the service

Women's services at Guy's and St Thomas' NHS Foundation Trust provide in-patient and outpatient gynaecology services and all services relating to pregnancy. Some of its specialist gynaecology and maternity services have national and international reputations. The maternity service provides care both within St Thomas' Hospital and in the local area. The trust's gynaecology service is split between Guy's Hospital and St Thomas' Hospital.

There are about 7,000 deliveries per year at the trust, 6,600 under the NHS and 400 privately funded. The community midwifery service sees women for antenatal and postnatal appointments, close to women's homes in GP's surgeries or Children's Centres. There are specialist antenatal clinics for women with medical needs and specialist midwifery teams for women with social needs. The Antenatal Day Assessment Unit (ADAU) provides emergency and follow-up antenatal care for women with specific pregnancy-related problems. All admissions have been triaged through the ADAU 24 hours a day since August 2015. The Hospital Birth Centre (the labour ward) has eleven delivery rooms (two of which can be used for bereaved families), four induction of labour rooms and three high dependency beds. There is a three bedded room for women having elective procedures and a three bedded room primarily for women requiring induction of labour. There are two obstetric operating theatres. The Home From Home Birth Centre (the birth centre) at St Thomas' Hospital, which is midwifery-led for low-risk births, has eight delivery rooms and two postnatal beds. About 20% of babies born at the hospital are delivered in the birth centre. There is also a home birth service.

There is a 19 bed antenatal ward and a 38 bed postnatal ward, which includes a four bed discharge lounge. The postnatal ward has two neonatal clinic rooms to provide checks on babies before discharge. The Westminster Maternity Suite is a private maternity ward.

There is a women's ultrasound service for all obstetric and gynaecology scanning at St Thomas' hospital.

The gynaecology service provides inpatient, outpatient and emergency services. The gynaecology outpatients' department is based at Guy's Hospital and provides a full range of general and specialist clinics. These treat gynaecological problems such as heavy or painful periods, fibroids and pelvic pain and advanced endometriosis. The cancer service is a regional centre for patients from South East London presenting with gynaecological malignancy (catchment area 1.8 population). It also provides a specialist one-stop diagnostic and assessment clinic for local women. St Thomas' Hospital provides an emergency gynaecological service at the Early Pregnancy and Gynaecology Unit, which is open seven days a week. There is a 27 bed gynaecology ward for inpatients.

Fifteen women and two relatives talked to us during the inspection, and other people contacted CQC about their experience of women's services. We spoke with 39 staff who included: consultants; doctors; midwives; nurses; other healthcare specialists; and support staff. We observed care

and looked at the care records and patient notes of mothers in the postnatal ward. We reviewed other documentation, which included performance information provided by the trust.

Summary of findings

We rated the maternity and gynaecology service as good, but some aspects of safety in maternity services need to be strengthened.

Women's services promoted innovation and encouraged their staff to provide responsive and woman-centred care and treatment. Staff were proud of working for the trust and felt they were able to contribute to improving services. Multidisciplinary teams of professionals with a range of knowledge and skills provided outstanding treatment and care for women with specialist needs, such as pregnant women with lupus, and women with endometriosis.

Staff gave women information and encouraged them to be involved in making choices about their care. Pregnant women were able to make choices about the birth they wanted.

The Antenatal Day Assessment Unit (ADAU) was often full to capacity and although there had been an increase in staffing levels, staff on occasions found it difficult to keep up with the demand. Following their initial assessment women sometimes had to wait a long time to be seen by a doctor or a specialist depending on the time of day, their level of risk and activity.

We found there was some confusion among midwives about whether or not all women needed to have a venous thromboembolism (VTE) risk assessment. VTE assessments were recorded on either of two electronic systems which did not interface and made it difficult for the trust to demonstrate compliance electronically. Assessments were also recorded in women's notes. Some babies had not received the new born blood spot screening test. This was on the risk register and some action had been taken to improve compliance.

Staff told us management encouraged openness. Incident reporting had increased, and there were systems in place for reviewing, investigating and learning from these. There was a trigger list of maternity incidents and evidence of changes to practice following incidents.

Gynaecology services gathered evidence about their services to make business cases for improvements to

Maternity and gynaecology

safety and responsiveness. For example the trust had agreed to increase consultant presence at the emergency gynaecology unit. The maternity service, however, did not have the recommended levels of consultant cover. Although this had been on the risk register since 2010 and approval for four additional consultants had been given there had been no increase in the number of consultants at the time of our inspection.

Policies and treatment protocols were informed by evidence based national guidance. Gynaecology and maternity services participated in a number of leading edge research projects and their practice was informed by research findings. Staff ran projects to test new ways of working, for example a project to give early warning of women liable to have a pre-term birth.

There was a programme of audits and outcomes for women and babies were generally in line with or exceeded national expectations. Although there was a lead consultant for audit and senior midwives had time within their roles to undertake audits and disseminate findings, systems for undertaking audits were still being developed.

However, the rate of caesarean sections was worse than the national average and action to reduce this had not achieved sustained improvement. Gynaecology clinics met targets for referral to treatment times.

There was effective working with other specialties in the trust and with local commissioning groups and GPs. Staff of all disciplines reported good team support and continuing professional development. Line managers supported nursing and midwifery staff, and the supervisors of midwives provided regular review and additional training for midwives. Junior doctors at all levels felt supported by the consultants and registrars

Are maternity and gynaecology services safe?

Requires improvement

Safety within Maternity and Gynaecology requires improvement as, whilst there were areas of good practice including staff training, there was an increased risk of patient harm due to a number of issues. Information about safety was not always comprehensive or timely and safety concerns are not consistently identified. Staff entered adverse events on the incident reporting system, and processes were in place for reviewing and investigating these, and sharing of learning. However, births that took place in the Antenatal Day Assessment Unit (ADAU) were not reported as incidents unless there were complications with the delivery. This meant there was no overview of whether there was any learning from these women delivering outside their intended place of delivery. Incidents were graded 'no harm' or 'low harm' when the woman or baby required further treatment or a transfer to another area.

Midwifery and nursing staffing levels were appropriately reviewed and staff followed the escalation policy when there were capacity problems on the labour ward and the ADAU. Although the number of midwives had been increased on the ADAU we observed and staff confirmed that on many occasions it was difficult to keep up with demand.

The maternity service did not have full seven day consultant cover, as recommended for a unit of this size. A proposal for an increase in consultant hours, to help achieve 24 hour seven day cover for the service, was approved by the trust with funding for four additional posts included in the directorate business plan in 2010. Due to financial pressures this had not been implemented at the time of the inspection. There was cover for both emergency and elective caesarean section lists. Gynaecology services had sufficient numbers of consultants and medical staff following the appointment of additional staff.

Some midwives were unclear if low risk women needed to have a VTE risk assessment and due to the number of systems, including two IT systems, in place for recording assessments it was difficult for the trust to demonstrate

compliance electronically. Some action had been taken to resolve the IT issues and ensure staff carried out assessments, but there was no overarching plan to resolve the issues

The five steps of the World Health Organisation (WHO) Surgical Safety Checklist in theatres had not been fully implemented. 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. Audits of compliance with the three steps showed they were not being completed for every procedure.

The risk that babies might not receive new-born blood spot screening had been placed on the risk register, with mitigation plans in place.

Women were monitored on the wards and appropriate review was requested when indicated.

The service had a clear safeguarding process which staff adhered to. The majority of the staff had completed their mandatory and statutory training.

Incidents

- There had been no never events reported between April 2014 to March 2015 in maternity services. There had been one never event reported in February 2015 under the Surgical core service that involved wrong site surgery for a patient with gynaecological problems. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)
- We saw from the incidents recorded, and midwifery and nursing staff confirmed, that staff in women's services reported incidents, and managers reviewed these and took action. For example, action was taken when equipment was found to be missing or faulty. Incidents were reviewed by the risk midwife or the matron daily and at the multidisciplinary risk meeting when needed. The meeting decided whether further action was needed, such as identifying learning. An example of sharing learning was the importance of monitoring fluid balance following a postpartum haemorrhage, which was included in the safety newsletter.
- There was a 'trigger list' of incidents for maternity services, such as unexpected admissions to NICU, still births, third degree tears and post partum haemorrhage. We were told women's services were encouraging staff to report other incidents, such as those related to staffing, and we saw examples of these reports. However, some staff said they did not always report occasions when they very busy. Births that took place in the Antenatal Day Assessment Unit (ADAU) were not reported as incidents unless there were complications associated with the delivery.
- The recent root cause analysis (RCA) of the stillbirth found that one of the contributory factors was the delay by midwifery staff in recognising and escalating difficulties in recording fetal heart rate to the senior medical team. This had resulted in the service taking action to devise a clear process for the management and escalation of difficulties in recording the fetal heart rate. Support for staff involved in incidents was available from supervisors of midwives (SoMs) and educational supervisors.
- There were other examples of lessons learnt from serious incidents. The management of major placenta praevia had improved, with the setting up of a pre-operation team huddle to plan and prepare staff to ensure risks were understood and a plan to address these was shared with all staff.(Placenta praevia is a condition in which the placenta partially or wholly blocks the neck of the uterus, so interfering with normal delivery of a baby).
- There were 226 reported incidents related to the gynaecology services, including colposcopy between 1 September 2014 and 29 August 2015. All the incidents had been rated as 'no harm' or 'low harm'.
- The staff at the Westminster Maternity Suite, for privately funded care, used the same incident reporting system as the NHS service. The midwife in charge of the ward attended the postnatal risk meeting regularly and the staff received the risk newsletter.
- Women's services shared learning from incidents with staff through newsletters and meetings.

Duty of Candour

- The Duty of Candour was part of the process for responding to incidents and there were checks for ensuring that women received a formal explanation when the incident resulted in medium or severe harm.

Safety thermometer

- Wards used the NHS Safety Thermometer to support the provision of safe care for women. The performance

review scorecard for women's services over the year from April 2014 to March 2015 indicated there were no falls with moderate or severe harm and only one hospital acquired pressure ulcer (grade two and above).

Cleanliness, infection control and hygiene

- We found all the ward areas, including obstetric and gynaecological units, were clean and tidy.
- There were separate hand washing basins with hand wash and a dispenser for disinfectant gel within easy reach in all the units. We saw staff regularly washing their hands and using disinfectant gel between patients. We observed staff wearing personal protective equipment (PPE) such as disposable aprons and gloves when required. All staff wore clean uniforms with arms bare below the elbow as required by the trust's policy.
- A number of cleaning audits had been carried out. One had scored the percentage compliance for the nine areas making up women's services, and considering separately catering, cleaning, estates, nursing, waste and patient television, radio and phone. The Labour Ward was deemed to be very high risk because of the critical work done there and a level of compliance less than 98% would be flagged as red RAG status, indicating a need for remedial action. Other areas were deemed to be merely high risk and a level of compliance less than 95% would be flagged as red RAG status, also indicating a need for remedial action. On average, 12 scores were flagged as red each month.
- Another cleaning audit was conducted on 26 May 2015 and covered just the antenatal ward. This checked particular items where present, in each area, scoring a one if the item had been properly cleaned and zero otherwise. This showed a very high level of compliance, except for one area, which was 85% compliant. An action plan had been drawn up, specifying the actions required for each non-compliant item in each area.
- There was an infection and prevention control (IPC) lead for the maternity and gynaecology department.
- On the day of our inspection, we noted one patient had been admitted to the birth centre with Clostridium difficile (C. diff). At the time the IPC lead had not yet been informed; the lead said they would soon follow this up and ensured staff adhered to the hygiene code of practice and the trust policy on infection control. Prior to this there had been two incidents of C. diff infection over the year from April 2014 to March 2015.
- 98% of admissions had been screened for Methicillin Resistant Staphylococcus Aureus (MRSA) between April 2014 and March 2015. There had been no incidents of MRSA infection in this period.

Environment and equipment

- The environment in the maternity and gynaecology areas at St Thomas' Hospital and the gynaecology outpatients' clinics at Guy's Hospital was generally uncluttered.
- The entrance doors to all wards were installed with an intercom system and there was a receptionist at the main entrance who ensured all visitors signed the visitors' book on entry and on leaving the premises. Staff used electronic swipe cards to gain entry to ward areas.
- We observed that equipment was readily available and had been appropriately cleaned, checked and serviced. In the labour ward, for example, the equipment in use was visibly clean and dust free.
- Clinical procedure trolleys used for fetal blood sampling, epidurals and instrumental delivery were cleaned, restocked and checked after each use. The contents were checked against the checklist that was attached to each trolley. We noted the date and staff signature on the checklist when equipment had been checked. Broken equipment would be labelled and reported for repair.
- The cardiotocography (CTG), electronic equipment used to monitor fetal heartbeat and uterine contractions during labour, was in good working order.
- The resuscitation trolleys in the Labour ward for both adults and neonates were checked daily by a designated midwife and appropriately labelled. We saw the checklist and the records that had been filled in daily and signed by a member of staff.
- The obstetric theatres and equipment were checked by the operating department practitioners who ensured all equipment was in good working order.
- We found one of the two clinical rooms in ADAU known as the quiet room had no call bell or emergency bell installed. This had been identified as a risk and plans were agreed to install bells. However, managers told us this had been delayed because the ceiling area had asbestos.

Medicines

- The trust had 24 hour per day clinical pharmacy support with resident pharmacists based on the St Thomas' site providing the out of hours service. Pharmacists visited

wards every day. 81% of patients had medicines reconciliation recorded within 48 hours of admission. Specialist pharmacists covered tertiary or highly specialised services.

- A variety of methods were used to promote medicines safety at the Trust. Posters promoted medicines safety tips that reflected learning from incidents reported. There was also a newsletter("Medicines safety news") and safety bulletins ("Safety Signals")
- Medicines were managed using an electronic prescribing and medicines administration (ePMA) system. Examples of the capabilities of this system included allergy checks, simple dose range checking, support for medicines reconciliation activities, and a built-in audit system. We were told agency staff had no access to the system and only permanent staff administered medicines. This reduced errors and restocking. In the postnatal wards, we were shown how the system operated.
- We saw that medicines were stored in automated cabinets within a key-coded medication storage room. The cabinets were linked to electronic prescribing. We were told only one person could log in to the system at any one time.
- Controlled drugs had been checked daily and fridge temperatures were monitored and recorded correctly. In the postnatal ward, we checked the controlled drugs with the midwife practice leader (MPL). They were appropriately stored and correctly recorded on the controlled drug register, which matched the drugs stored. The MPL confirmed there had been no recent medication errors.
- By each patient's bed was a lockable cupboard where patients' medicines to take away (TTA) were safely kept until patients were discharged home.

Records

- The maternity service had introduced Badgernet, an electronic patient record system, on which staff recorded the key information for each woman.
- The hand-held notes for women using the maternity service were comprehensive with several pages of relevant advice and information for antenatal women.
- We looked at two patients' care notes and observation charts on the postnatal ward and found them detailed and appropriately maintained.
- Gynaecology ward nursing staff carried out standard risk assessments for each patient, such as the risk of falls, risk assessment scoring system for pressure areas and the malnutrition universal screening tool (MUST) score for nutrition. The records we saw showed that these assessments had been carried out on admission and reviewed when the patient's condition had changed.
- Staff recorded observations of babies in the postnatal ward in a neonatal record booklet. The booklet was started by the labour ward midwife; records were then maintained in the postnatal ward until the new born babies were discharged home. We noted all observations and daily recordings for the new born babies were documented in the booklet, including a baby wellbeing assessment and a feeding assessment record if a woman encountered any feeding problems.

Safeguarding

- Women's services had clear safeguarding processes. Staff had an awareness of the importance of safeguarding women and children from abuse and harm. Staff we spoke with were able to explain what would constitute abuse of women or babies. They were able to tell us the actions they would take in the event of witnessing abuse.
- Midwives and nurses were aware of the action to be taken where they identified women who had female genital mutilation.
- There was a safeguarding lead for maternity and gynaecology services who dealt with safeguarding matters and ensured staff followed the safeguarding procedures. The safeguarding lead was closely involved in all potential safeguarding matters; they liaised with the specialist midwives involved with mental health issues and substance misuse and with the midwifery team serving young women up to 21 years old.
- The safeguarding lead attended weekly team meetings as well as multidisciplinary meetings which might involve the perinatal mental health team, the drug team concerned with substance misuse and social services. There were good processes for handover to the special care baby unit and the multi-agency team which took the lead in any safeguarding investigations.

Mandatory training

- The performance review scorecard for women's services indicated 85.3% of staff had received mandatory training. This was the average monthly figure between October 2014 and February 2015.

- Midwives attended mandatory training for 23 hours per year. This included CTG interpretation, mentorship, drills and skills, infection control, safeguarding and duty of candour. The majority of the staff we spoke with said they had completed all their mandatory and statutory training.
- Midwives and new medical staff attended the mandatory training on the issue of bereavement. This training was given by the bereavement midwife.
- Medical and midwifery staff used the simulation centre to practice obstetric emergencies such as post-partum haemorrhage and emergency caesarean sections.
- In gynaecology uptake of mandatory training varied with an overall compliance of 81%. For basic life support and child protection level 2 training 95% of staff had completed training and 91% had completed infection prevention and control training.

Assessing and responding to risk

- Women who attended their first antenatal appointment for booking were given an assessment of needs that included their health and social needs. This identified, for example, their obstetric history, medical conditions and whether they had a history of substance use. Community midwives referred women with additional needs to the appropriate specialist clinic or to one of the specialist community midwifery teams. A high percentage of women (90.6% in 2014/15) were booked before 13 weeks pregnancy.
- When women used the telephone service the information should have been logged on the IT system or entered in their notes. This information might be necessary for staff to gain a full clinical picture and assess risk. When calling outside the hours of the dedicated telephone service, information was not always logged on the IT system or entered in the patient's notes. Medical and midwifery staff we spoke with confirmed that there was inconsistent recording of phone calls that did not go through the telephone advice service. The risk had been identified and had been on the risk register since January 2013 and some action to mitigate the risks had been taken. Further action to extend the dedicated phone line to 24 hours has not been approved due to funding constraints.
- The triage service had operated in the ADAU 24 hours a day seven days a week since August 2015. There was a high level of demand from women who had self-referred or been referred by their GP because they had concerns, and women who had started labour. Urgent cases such as women in labour, women with bleeding or with reduced fetal movement were prioritised. The trust protocol for the ADAU specified that women in labour should be admitted within 30 minutes of arrival. The midwife lead reported the unit achieved this on 70% to 80% of occasions.
- We asked staff in the ADAU why there was a resuscitaire in the unit and we were told this was for women who delivered in ADAU. There was some confusion about the number of births in the ADAU; some staff told us that four births had taken place on the ADAU during the first week of September 2015 and others told us there had been six births between 1 September 2014 and 31 August 2015. The trust has since confirmed that between 1 April 2014 and 7 September 2015 seven births had taken place in the ADAU.
- The risk team said the births in ADAU were considered to be born before arrival (BBA) but they were unsure. Trust policy identifies births on ADAU as born before arrival. These births were not reported as incidents and were not reviewed unless there were complications with the delivery. Therefore there was not an overview of any learning from these women delivering outside their intended place of delivery. The trust has advised us they will review after the inspection and report them as incidents going forwards. Midwifery staff told us women sometimes gave birth in the unit because there were no beds available on the hospital birth centre (labour ward). We were also told that women were sometimes admitted to the home from home birth centre, if the hospital birth centre was busy.
- The trust target for patients receiving a VTE risk assessment was 95%. There were a number of problems related to VTE assessments including recording and clinical care. In maternity there were three different systems for recording VTE assessment, depending on whether the admission was related to a delivery or not. There were two IT systems which did not interface. Compliance on the EPR represented non delivered women & the compliance from BadgerNet represented delivered women. This was confusing as there was no narrative with the dashboards. It made it difficult for the trust to demonstrate compliance

electronically and it would appear that the service had been non-compliant for 18 months. To accurately assess compliance audits of hand held notes were carried out. Following the inspection the trust provided information about an audit of 30 sets of hand held notes in September 2015 which found 100% compliance.

- There was a lack of clarity among staff about whether some low-risk women were expected to have a recorded VTE assessment. When we raised the problem of some pregnant women not receiving a VTE assessment during our inspection, maternity services provided an action plan, dated 8 September 2015, to ensure compliance with the policy. The expectation was that midwives should complete a risk assessment at booking to be repeated at every antenatal or postnatal admission and after delivery prior to leaving the hospital. Midwives referred women at high risk of VTE to the obstetric or haematology clinic at the time of booking. The action plan also included adding VTE assessment to the WHO surgical safety checklist. For midwives recording the assessments process was added to mandatory training for midwives. An audit to evaluate the accuracy of calculation of VTE score and dosage had been completed earlier in 2015.
- Information provided by the trust following the inspection showed the problems with VTE assessments had been discussed at the Maternity Services Performance Report Monthly throughout 2015.. Although some audits had been undertaken of small cohorts of women in 2014 and 2015 and some action had been taken to improve compliance, there was no overarching plan to address the issues and on-going monitoring of compliance.
- Maternity and gynaecology services had a protocol in place to ensure patients who were unwell received appropriate care and treatment. We noted that an early warning score (EWS) chart was used for woman on maternity and gynaecology wards. The chart gave staff directions about how to escalate care in the event of a patient whose condition was deteriorating. In the postnatal ward, we checked two charts that were in use and found they had been filled in appropriately by staff.
- We were told babies who were unwell or who had developed jaundice within 24 hours of admission to the postnatal ward would be seen by a paediatrician. These babies were observed closely and observations recorded every four hours. Observations were every two hours for babies with meconium stained liquor at delivery and for babies born after 24 hours of ruptured membranes.
- Staff followed the World Health Organization (WHO) surgical safety checklist (SCC) in the obstetric and gynaecology theatres, but did not use it correctly in all procedures. The trust undertook regular audits which combined direct observation of theatre practice and checks on documentation in clinical notes. The trust expectation was 100% compliance with the three stages of the SCC (sign in, time out and sign out). The audit results for February 2015 (published in August 2015) were that four of 25 obstetric procedures were not compliant because, although the three stages were performed, the 'time out' was done after the skin incision in four cases.
  There were 15 gynaecology procedures audited (12 day surgery unit and three main theatre). In three of these one or more stages were not completed. The audit did not include the pre-list brief and post-list debrief, the two steps of the five steps to safer surgery that promote teamwork and learning. The obstetric surgery teams did not routinely follow these two steps. Action points following the trust audit included the proposal to establish a surgical safety group to oversee initiatives to improve compliance. These included updating guidance relating to use of five steps to safer surgery in line with the national safety standards for interventional procedures.

- The NHS new-born blood spot (NBS) screening programme aims to identify rare conditions that can lead to serious illness and development problems. Midwives carried out heel prick tests when babies were five days old. There had been occasions when tests were not done, or were repeated unnecessarily. A risk that babies might not receive new born blood spot screening (rather than there being omissions in the test itself) was identified in 2014. This was on the risk register with mitigation actions, such as training and checks. In June 2015, five babies were identified as not receiving the new-born blood spot test. This was recorded as a serious incident and had been investigated with NHS England involvement. The trust had agreed further action, including a new standard operating

procedure, to prevent a reoccurrence. As of September 2015 the trust remained an outlier for performance and was discussing the possibility of appointing a screening co-ordinator.

Staffing

- The staffing for maternity and gynaecology services was reviewed every year as part of the business planning process. The director of midwifery and head of gynaecology was of the opinion that there were enough midwives, nurses and support workers employed to keep women safe. Staff in maternity services were flexible and were asked to move around the clinical areas during peaks in activity. The ratio of midwives to births was 1:25, better than the England average of 1:27.
- Senior nursing staff recorded staffing levels and the numbers and acuity of women on maternity and gynaecology wards each day. The information uploaded on to the shared drive for the attention of the chief nurse and the director of nursing. Midwifery staff told us there was a daily review by 7:30am of the acuity of the patients, the caseload and the staff numbers. Staff informed the manager on call by 8am if additional bank or agency midwife was needed for the shift. However, it was not always possible to get replacement staff at short notice
- The trust informed us there was an increase of 1.5 WTE midwives in the ADAU in 2015/16 and that staffing levels across maternity are reviewed on an annual basis. However, we observed, and staff told us, there were many occasions when there were insufficient staff in the Antenatal Day Assessment Unit (ADAU) to deal with the demand. The unit combined a triage service with providing care to women who had appointments, for example at the consultant-led breech clinic. Midwives sometimes left the unit to take labouring women to the labour ward, and did not return for several hours. On one occasion in August there were between 10-15 patients waiting to be seen in ADAU by either a midwife or a doctor, with only one midwife on duty. On Monday night (7 September 2015, the week of the inspection), 22 women were seen in the ADAU unit from 8pm. At the time there was one midwife and one maternity support worker on duty for the night shift. When this was raised with a senior member of staff, a midwife was deployed from the birth centre to assist. This was in line with the escalation policy.
- The labour ward had three core teams of midwives, with a senior midwife for each team who coordinated ward activity and did not usually undertake clinical duties. Two midwifery practice leaders supported staff on every shift. There were two scrub nurses on every shift to cover the two obstetric theatres. There were times when the labour ward was very busy and there were challenges meeting demand with available resource. Staff told us, and we saw from incidents reported, that the escalation policy was used on these occasions. The manager on call was contacted, and decisions were made about finding additional staff or deploying staff from other parts of the service, such as specialist and birth centre midwives. Managers sometimes worked clinically. We were told midwives were not always able to provide one-to-one care in established labour, but this information was not recorded and did not appear on the maternity dashboard.
- In 2014 10 newly qualified midwives were used to cover for midwives on maternity leave. Currently there were 7.2 whole time equivalent (WTE) of midwives on maternity leave and we were told this arrangement had been extended in 2015. Senior management acknowledged this was not an ideal skill mix for the labour ward, but thought it was better than employing agency midwives. Supervisors of midwives and the practice development midwife supported newly qualified staff.
- The ratio of midwife to women in the postnatal ward was 1:8. The midwife practice leader (MPL) confirmed they were 99% compliant with this ratio.
- Community midwives caseloads averaged 250, which was in line with recommended numbers. The community matron felt there were an insufficient number of community midwives for the provision of postnatal care. At present there were only a few postnatal clinics. However, work was in progress to plan a 'Fit for the Future' postnatal project which involved deciding where to set up postnatal clinics. The outcome of this project will inform the number of staff required in the future.
- Sickness/absence rates were low (2.6% compared to a target of 3%). Bank and agency staff were requested when there were gaps in the rota in gynaecology and maternity wards. Ward managers said they had to inform the trust's agency and bank booking department when they needed to book an agency worker. However, there had been occasions when the booking

department had been informed in advance only to find that the request had not been carried out, leaving the ward short staffed because agency staff had not been booked for the days required. Managers had raised this issue with the booking department but the problem had yet to be resolved. In addition, staff told us bank or agency staff were not always available. It was also difficult to make last minute arrangements when members of staff went on sick leave at short notice. The labour ward used around 10 agency midwives per week.

- The nursing establishment on the gynaecology ward was 27 whole time equivalents and at the time of the inspection there were three vacancies. There were no vacancies on the colposcopy unit.

Medical staffing

- The recommended obstetric consultant cover for labour ward is 24 hour, seven day for a service of this size, which equates to 168 hours. There was currently 72 hour cover. (Monday to Friday 8:30am to 9pm and four hours on Saturday and Sunday). However, there was dedicated consultant cover for four hours (Monday to Friday) to do only elective caesarean sections. We were told of the plan to have 105 hours of consultant cover for the labour ward in order to provide the same cover seven days a week. A proposal for an increase in consultant hours, to help achieve 24 hour seven day cover for the service, was approved by the trust with funding for four additional posts included in the directorate business plan in 2010. However, due to financial pressures this has not been implemented. The trust told us it remains a priority for the trust and discussions have been held with commissioners.
- The trust has allocated additional consultant time into antenatal and postnatal services to mitigate some of the risks with the delay in implementing 24 hour cover on the labour ward. There was four hours of consultant cover seven days a week for the antenatal ward, but in the postnatal ward there was four hours of consultant cover five days a week (Monday to Friday). In the triage Antenatal Day Assessment Unit there was four hours dedicated consultant presence on Monday and Wednesday to carry out elective assessment and the breech clinic.
- In the maternity units there were three tiers of doctors in training on duty. Junior doctors said they were happy with the rota system. They got a week off after the night rota and they had a full 27 days of annual leave.
- There was adequate anaesthetic cover for the obstetric service. There were 11 anaesthetic consultants, who were on the obstetric staff rota. There was an anaesthetic consultant present in the Labour ward Monday to Friday (8:30am to 5pm) and a second consultant worked four hours every morning (Monday to Friday) to do elective caesarean sections. During the day there was cover from a senior and a middle grade doctor in training and out of hours one doctor in training with back up from the main theatres or from another local hospital.
- There were adequate numbers of gynaecologists to provide safe services to women. Three new consultant posts had been created to improve care and to make sure there was consultant cover for emergency gynaecology cases every day. This meant there were now 14 consultants for gynaecology alone. Additional junior medical staff had recently been appointed because of concerns that there was a risk of delays in treatment for patients as doctors are covering obstetric activity at night.

Handover

- We observed a medical handover in the morning. The team that was on night shift and the team coming on day shift were present. Both the obstetric and the anaesthetic staff were present as well as doctors in training. We noted there were no midwifery staff present for the medical handover. We were told the midwifery co-ordinator was sometimes present but this was not a routine.
- During the medical handover, a portable board with details of patients was wheeled into the staff room. The information on the board was split into sections. There was no printed sheet given to the medical staff. The portable board was kept in a side office to maintain confidentiality of patient information.
- The midwifery team had their own handover period in the labour ward and in each of the wards.
- Printed handover sheets are provided on the antenatal, postnatal and gynaecology wards

Maternity and gynaecology

Major incident awareness and training

- The hospital had a site control room which operated at all hours and provided a single point of coordination.
- Staff we spoke to were aware that there was a procedure for managing major incidents and on wards we saw there was a major incident folder.

Are maternity and gynaecology services effective?

Good

Maternity and gynaecology services provided effective care, which we rated as good. The trust's policies and treatment protocols used evidence based national guidance. Women's services participated in local initiatives to improve outcomes for women and babies.

The comprehensive gynaecology service included sub-specialties providing leading-edge treatment.

The rate of caesarean sections remained higher than the England average in spite of action to lower the rate. Other outcome measures for maternity services were similar to the England average, in spite of the high risk population of women giving birth at the trust. Maternity services supported mothers to breast feed and breast feeding rates were better than the England average.

There was effective multidisciplinary working with other services in the trust and with external organisations. Staff of all disciplines said they benefitted from learning and continuing professional development. Nursing and midwifery staff said they were well supported by their line managers. The supervisors of midwives provided additional clinical supervision and innovative training to midwives. Doctors in training at all levels felt they received appropriate support and training opportunities.

The process for notifications of termination of pregnancy for fetal abnormalities was not robust. The trust had not yet implemented the recommended guidance on the disposal of fetal remains from March 2015.

Evidence-based care and treatment

- The trust's policies and treatment protocols were based on national guidelines from the National Institute for Health and Care Excellence (NICE) and professional organisations such as the Royal College of Obstetricians and Gynaecologists (RCOG). Staff knew where to find policies and local guidelines, which were available on the trust intranet.
- The trust contributed data to the national Neonatal intensive and special care (NNAP) programme (NNAP) and to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK).
- There was a trust audit team and information was available on undertaking clinical audits on the shared drive. There was an annual programme for audit for women's services, agreed with the divisional clinical audit lead and informed by NICE quality standards, serious incidents and data from dashboards. Newly published NICE guidance, such as the quality standard on multiple pregnancies were checked against current practice. Doctors in training undertook audits with support from senior medical staff. At the end of each financial year the audit lead reviewed the completed audits and followed up those that required completion. Gynaecology audits approved for 2015 included Quality control of urodynamics investigation at Guy's hospital and an audit on NICE guidelines on urinary incontinence management in females. Maternity services had completed stage one of a summative audit of massive obstetric haemorrhage.
- There was a Consultant audit lead with time allocated in her job plan. There was no named audit midwife however, members of the clinical governance team and senior midwives had time within their roles to undertake audits and disseminate the findings. There was no dedicated administrative support for audit and the systems for undertaking these audits were still being developed
- Audits were presented once a month at multidisciplinary team meetings. Audit findings were uploaded onto the intranet for staff to view and were reported in the newsletter emailed to all staff. The audit committee met on alternative months and the meetings minuted.
- There was no system to check that HSA4 notifications of termination of pregnancy for fetal abnormalities had been submitted to the Department of Health, which is a statutory requirement. We saw that the forms were completed, but there was no record that the forms had been submitted.
- The service was not currently following guidance on the disposal of pregnancy remains issued by the Human

Tissue Authority in March 2015. There was a process in place for the disposal of fetal remains, including burial. If women asked for information about this, it was provided. However, the new guidance expects services to offer and record the woman's choice, including the opportunity to have a religious ceremony. There had been meetings to discuss the guidance and the service was in the process of producing a leaflet for women and their families. This will facilitate women having choice and giving their consent to what happens to the fetal remains.

Pain relief

- Women giving birth had a full choice of pain relief, including epidurals. Midwives provided support to women who did not want to use pain relief. Women who had undergone caesarean section said they had been offered pain killers regularly and that when they requested medicines they received it promptly. We observed mothers being asked if they required pain killers during a drug round in the postnatal ward. One patient was given extra pain relief on request following a caesarean section the day before.
- One woman had waited nearly two hours before she was given pain killers in the Antenatal Day Assessment Unit. The staff had to be reminded more than once.
- Nursing staff regularly checked that patients on the gynaecology ward were receiving appropriate pain relief.

Nutrition and Hydration

- Midwives and healthcare assistants supported mothers to breastfeed. The clinical infant feeding lead trained them and provided advice to mothers. There was a breastfeeding drop-in session on the postnatal ward. In June 2015, the maternity service was accredited by the United Nations Children's Fund (Unicef) for their Baby Friendly Initiative (BFI). The initiative adopted internationally-recognised standards of best practice in the care of mothers and babies. From April to June 2015, 90.8% of women breastfed initially, better than the national average.
- Women on the wards had a choice of menu and hot meals were provided twice a day. One woman said the meals offered were very good with lots of choices and that they were also nutritious. We observed a three course lunch being served in the postnatal ward. There was a selection of hot meals and women were offered a choice. Snacks were available from the kitchenette on the postnatal ward.

Patient outcomes

- When benchmarking data was available, this demonstrated that outcomes for women were good. In maternity services, there were 4.0 stillbirths per 1000 deliveries between April 2014 to March 2015, compared to a national average rate of 4.2 per 1000. The average monthly figure for third degree tear during a vaginal delivery was 4.5%.
- 62 day urgent GP referrals was below the target of 85%, but had increased from 71% the previous year to over 80% each month between April and September 2015. Performance was better for patients who were referred directly to GSTT, with over 90% of patients meeting the standard in both 2013/14 and 2014/15. Staff informed us that they were working with neighbouring hospitals to reduce late referrals.'
- The caesarean section rate was worse than the national average. CQC had previously identified the rate of caesarean sections in the trust as an outlier, higher than expected. The trust took action to bring the rate down, but this had not resulted in sustained improvement. The rate was above the national average at the time of our inspection, even when this was adjusted to allow for the high risk women using the service. The adjusted rates for caesarean sections were 25.6% for women giving birth for the first time and 22.7% for women with subsequent births, compared with the England averages of 22.3% and 21.8% respectively. Over the period April 2014 to March 2015, 30.9% of NHS deliveries were by caesarean, compared to an England average of 26.0%. For elective caesarean section, the figures were 11.5% compared to an England average of 10.9%.For emergency caesarean section, the figures were, 19.4% compared to an England average of 15.1%.
- 66.0% of private deliveries were by caesarean section.
- Senior staff in maternity were aware of the need to reduce the rates of caesarean section. The monthly caesarean section rates were recorded on the maternity scorecard and were discussed at the monthly intrapartum subgroup meetings and at the monthly strategic/operational obstetric meetings. These

meetings were multidisciplinary. There were regular caesarean section audits. The caesarean section guidelines had been revised in discussion with the SE London cluster.

Competent staff

- Staff of all disciplines in women's services said they were supported to develop skills through training and continuing professional development.
- There was an appropriate number of midwives qualified and experienced in specialist areas. This included screening, perinatal mental health, bereavement and female genital mutilation. The service had four consultant midwives; one covered the antenatal period, one promoted normality around birth, one covered public health and one was a research midwife. There was a consultant nurse for the gynaecology service. The Supervisors of Midwives (SOMs) provided innovative training opportunities for midwives. The SOMs carried out annual reviews of all midwives at the trust and had the highest completion rate of all London hospitals.
- Students and newly-qualified midwives and nurses in women's services held preceptorships, with a year of practical experience and training, supported by a practice facilitator.
- Most post-registration programmes were provided by Kings College, London and London South Bank University. The trust had an arrangement with Middlesex University, which provided training for midwives to undertake the Examination of the Newborn course.
- Junior doctors confirmed they received good training and had opportunities to gain competencies. Their Objective Structured Assessment of Technical Skills (OSATS) had been signed off appropriately.
- There was an additional teaching session every Friday afternoon. The middle and senior doctors in training were able to attend as they were free of clinical work.
- Junior doctors in training felt supported by the consultants and registrars. They said they had never felt unsafe working with the team. Consultants had allocated time in job plans for supervision and training and 100% of consultants had completed supervisor training.

Appraisals

- Monthly figures indicated that over 75% of appraisals for non-medical hospital based staff were completed.
- At least 80% of community midwifery staff had had their annual appraisals and the remainder had dates arranged for their appraisals.
- In gynaecology 100% of nursing staff had had an appraisal and consultants had completed their revalidations.

Multidisciplinary working

- We found effective multidisciplinary working at all levels of women's services. There were good links with other services in the trust to promote effective care and treatment.
- Gynaecology services, such the menopause clinic, the oncology clinic and the continence and urodynamic service were run by multidisciplinary teams of staff from different professions. Specialist gynaecology and antenatal services worked with other specialties within the trust. For example, the endometriosis clinic team included gynaecologists, a nurse specialist, surgeons and urologists. The clinic also work closely with the trust pain management team. Staff working in the fetal medicine unit included neonatologists, midwives, fetal medicine specialists and ultra-sonographers. The unit had access to other specialties, including renal, neonatal and cardiology.
- We observed effective communication between midwifery staff and consultants on the labour ward. The multidisciplinary intrapartum sub group met every day on the labour ward to discuss patients and risk. A weekly meeting was held to discuss on-going cases and a monthly meeting to discuss particularly difficult cases.
- There was paediatric representation at antenatal, in-patient & postnatal meetings and out-patient community meetings.

Access to information

- The introduction of BadgerNet, the electronic patient record system in maternity services was expected to improve access to patient information. The risks associated with its introduction had been logged and mitigation action taken.
- Midwives did not have access to hospital electronic systems while working in the community clinics and were therefore unable to obtain information such as test results or to enter information on the system. Clerical staff were sent duplicates to enter and there were longer term plans of providing laptops to community staff.

- Staff had access to guidelines, policies and procedures via the trust intranet.

Seven day working

- The Early Pregnancy and Gynaecology Unit (EPAGU) was open seven days a week, closing at 6pm on weekdays and 3:30pm on Saturday and Sunday, with scanning on Sunday as well.
- Consultants in women's services attended the hospital every day. The Emergency pharmacy service was available at St Thomas' hospital 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed that their consent had been sought prior to caesarean sections and other procedures. They described how procedures had been explained to them, and their consent had been obtained before treatment began. We saw patient signatures in the records we checked.
- Staff we spoke with were clear about their responsibilities to gain consent from patients. We saw staff asking patients for their consent before carrying out personal care and before checking their new born baby in the postnatal ward. Staff had knowledge of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) application process. They said they would contact senior practitioners if they had any concerns regarding a patient with a capacity problem. Staff said they would contact the learning disability team for assistance if consent was an issue for people with a learning disability.
- Maternity services had carried out discussions internally and with solicitors about updating their process for consent in light of a recent high court ruling on an obstetric case.

Are maternity and gynaecology services caring?

Good

We rated the caring domain as good. Women using gynaecology and maternity services were complimentary about the service and the care they received. They said the medical, midwifery, nursing and support staff were polite and caring.

Women were encouraged to discuss their birth plan, choices and decision-making about the birth of their baby with the midwife. There was bereavement support for women who had a still birth or a termination of pregnancy because of fetal abnormality.

Compassionate care

- Women we spoke with said that nursing and midwifery staff were generally polite and caring.
- Women who gave birth at St Thomas' hospital gave similar rates to the England average in the national survey of maternity services, which took place in February 2015. There were 195 responses for the trust. For example, women rated the trust positively when asked whether they were treated with respect and dignity. However, a small number of women we spoke with felt the attitude of one or two midwifery staff could improve.
- The NHS Friends and Family Test (FFT) asked women using each department if they would recommend the service to their friends and family. In July 2015, the labour ward had a response rate of 35%, and 94.6% of those responding would recommend the service. The birth centre had a low response rate of 10% and 100% recommending. The England average recommending for labour wards was around 96% between March 2015 and February 2015. The postnatal ward had a response rate of 33.6% and, of these, 89.9% recommending, compared with the England average of 93%. Antenatal care and postnatal care in the community had very low response rates of 2.6% and 1.9% respectively.
- The average Friends and Family Test score between April and August 2015 for the number of women who would recommend the gynaecology ward was 96.8% The FFT response rate was 40%. The FFT identified the need for better food.

Maternity and gynaecology

Understanding and involvement of patients and those close to them

- In general, women were involved in their care and received explanations of the choices available and the treatment options (if applicable). Women in the maternity survey said they were well informed and they felt involved in their care and treatment.
- Women using maternity services confirmed they had been well informed during the antenatal period. Some women in the antenatal ward said the information they had been given was good and their consent was sought before treatment was given. They were generally happy with the care. However, one woman said that she was waiting for an elective caesarean section but was told the date had been changed from Tuesday to Friday. She felt that the date might change again.
- Women who had a caesarean section said the midwife and the consultant explained the reason and the procedure. They said they had seen the anaesthetist, who had explained the options for pain relief, before they signed the consent form.
- Women said they had been involved in decisions about their choice of birth location and the risks and benefits of each. They said they were well supported after their decision.
- The antenatal clinics had posters on display and information leaflets were readily available. In the postnatal ward there was information about support available in the community for women who wished to breastfeed.

Emotional support

- Five women we spoke with in the postnatal ward said the staff were very helpful and caring. They felt very well supported by the doctors, midwives and support staff during labour and after the delivery of their baby.
- Women in labour and in postnatal care were allowed to have their partners to stay overnight to give them further support.
- Women going through a mental health crisis would be seen promptly by the perinatal mental health team, which included a psychologist.
- The service had a lead midwife for bereavement counselling, in the event of a stillbirth or a sudden death. Women were assisted with memories packs and remembrance services. The bereavement midwife provided support and follow-up, in conjunction with the obstetricians. The bereavement midwife also provided support to women using the termination of pregnancy service.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good.

Women's services provided a full range of services geared to individual need.

Women using maternity services were given the choice of a range of options for birth, including a midwifery-led birth centre and a community midwife-led home birth option, subject to an appropriate risk assessment. Midwives provided care and support for vulnerable women and teenage mothers. Women with medical conditions attending the antenatal clinics were appropriately booked and saw members of a consultant-led team.

There was a single point of admission for all expectant women through the triage antenatal day assessment unit (ADAU). Women expressed disappointment at the long delays in seeing a doctor and there was the occasional delay in seeing a midwife initially as they arrived in ADAU.

Gynaecology services were responsive to women's needs, particularly through one stop and rapid access clinics. the service performed well in meeting referral to treatment time targets. The gynaecology outpatients department (GOPD) was well managed and all follow-up appointments were made on the day of their visit. The rapid assessment clinic for women referred to cancer services operated a one-stop shop for diagnosis and assessment.

Women's services staff maintained effective communication with local GPs and other healthcare providers.

There was evidence of learning from complaints and feedback.

Maternity and gynaecology

Service planning and delivery to meet the needs of local people

- The trust 'Developing the GST Clinical Strategy' in November 2013 capped births at 6,600 NHS births per year in order to meet the demand for maternity services within resources. Antenatal and postnatal services were close to local women's homes. Specialist services for high risk women from the local area and further afield were provided alongside the full range of choices to suit women's needs and preferences.
- Gynaecology services provided a full range of services to local women and specialist services to women from other areas.
- Women's services maintained relationships with local GPs and other healthcare providers. This had ensured women received continuity of care when discharged from the hospital.

Meeting people's individual needs

- There were five community midwifery teams, which provided antenatal and postnatal care close to women's homes. There were seven caseload teams: six of these covered the geographical areas and one team, known as the Teen Phase Team, supported teenage parents up to 21 years old. There was also a home birth team. The caseload midwives in the community arrange their own antenatal appointments and provided continuity of care throughout the care pathway.
- There were centres in in the community for vulnerable women. the community teams were supported by a link consultant obstetrician and portable scanners were available.
- There were feeding support groups in the community. We saw a map on the wall in the postnatal ward indicating where the groups were based. A breastfeeding co-ordinator and a health visitor worked full time in the feeding cafes in the Southwark area and there was a breastfeeding coordinator in Lambeth three days a week.
- There was a consultant midwife who supported normal birth without medical intervention. The supervisor of midwives team also support midwives in the promotion of normal birth through study days. The topics included vaginal breech, water birth and aromatherapy workshops. Midwives we spoke with showed their commitment to the promotion of normal birth. Midwives met women to discuss and agree a labour plan and there was a care planning clinic for women if they wanted to discuss the birth further. A plan of care was agreed with the patient and placed in her notes. The 'outwith guidelines' clinic provided advice and support for women with complex obstetric conditions to support them in having a normal delivery. An audit of this clinic showed a positive response in patient experience and an increase in women achieving normal delivery.
- When women moved from the birth centre to the labour ward because the labour was not straight forward, their midwife accompanied to provide continuity of care.
- Women who had had a previous caesarean section could attend the VBAC (vaginal birth after caesarean) clinic which was run by a consultant midwife. There was a one-stop breech clinic at the ADAU for women with breech presentation during pregnancy.
- There were specialist multidisciplinary clinics at St Thomas' hospital for women with medical needs, such as diabetes, sickle cell, and lupus. The clinics received referrals from outside the local area as well as caring for local women. Women with tocophobia (an abnormal fear of giving birth or becoming pregnant) were referred to a consultant psychiatrist.
- There was close liaison with social services for mothers with learning difficulties or mental health issues. There was a perinatal mental health team to provide support for women with mental health issues. Two teams of hospital based midwives provide continuity of midwifery care to women with a range of medical, social and psychological problems such as fetal and maternal cardiac abnormalities, renal disease and mental health issues.
- There was a specialist dementia-trained nurse to support women with dementia. Over the year from April 2014 to March 2015, 5 women had been admitted to the gynaecology ward with dementia. These were all screened for dementia within 72 hours of being admitted.
- Female clinicians were available, for example in the colposcopy unit, and patients were told to inform staff if they preferred to be examined by a female member of staff. There was a chaperone policy followed by staff in gynaecology services.
- Women on the gynaecology ward for elective surgery had pre-admission assessment and they were given patient information on what to expect on admission. They received further advice before going home and

patients received a follow-up phone call from the ward after discharge. Patients were given the ward contact details and were given details about who to contact, either the ward, GP or A&E department.

- The Early Pregnancy and Gynaecology Unit (EPAGU) saw women with urgent gynaecological problems, referred by their GP, and women up to 18 weeks pregnant, who were able to self-refer for conditions such as pain, bleeding or severe vomiting. Day care was provided for women with hyperemesis and there was a one-stop clinic specialising in anaemia and menorrhagia.
- The Fetal Medicine Unit (FMU) provided a one-stop screening service for pregnant. There was easy access for women and they were given the results without delay. There was a good system for action and follow-up in response to women's needs. Women were offered screening for fetal abnormality in their first trimester. Women were given three to four opportunities to decline if they did not want screening. The sonographer checked that the women wanted screening as well as a dating scan. Women received the results on the same day and if there was a high risk, they were immediately counselled. If they decided on invasive screening the result was available in 48 hours. A fetal medicine midwife phoned the woman with the result and invited her in to discuss it. Women booking after 14 weeks gestation were appropriately offered quadruple testing. The women were given a phone number to ring for follow-up and support. There was an answering machine for the women to leave a message if necessary. When there was a fetal abnormality, women were offered the option of a referral to the Termination of Pregnancy (TOP) service
- There was a translation service for women whose native language was not English and who required a translator. We observed a translator assisting a women in the postnatal ward.
- There were a variety of menus available to women on the wards, such as halal and kosher meals and modified diets were available through the dietetic service.

Access and Flow

- At times of peak demand, staff were often unable to maintain the flow of women through the Antenatal Day Assessment Unit, which operated a 24 hour triage service. Women reported that they had waited several hours, after their initial assessment, in ADAU to see a midwife or a doctor before they were triaged to the appropriate ward. The trust has told us that following their initial assessment women sometimes had to wait a long time to be seen by a doctor or a specialist depending on the time of day, their level of risk and activity. The trust provided an audit/attendance sheet for the ADAU for the morning of 9 January 2015. It showed that all the women were seen by a midwife within an hour of arrival.
- Women in the ADAU told us the staff in ADAU were always busy and that at times members of staff did not explain to them what was happening or why they were waiting so long. One patient told us that the midwife had tried to phone the antenatal ward but no one had picked up the phone. The patient was not told if there was a bed available until four hours later, around which time she was then transferred to the antenatal ward, having waited 12 hours. When we asked midwives why the women delivered in the ADAU, we were told this was usually when there were no rooms or beds available in the labour ward and that it was very rarely because women were in advanced labour when they arrived at the ADAU.
- The occupancy levels of wards were not high compared to the national average, but there were times when the maternity service had problems with dealing with demand. There was an escalation policy to address problems with access to beds. The maternity unit had been closed to admissions three times between April 2014 and March 2015.
- The antenatal ward had 19 beds and over the period from April 2014 to March 2015 the average occupancy was 73%. The Birth Centre had 10 beds and the average occupancy was 54%. The Labour ward had 22 beds and the average occupancy was 65%.The postnatal ward had 38 beds and the average occupancy was 83%.
- The system for women phoning in for advice was inefficient. It was sometimes difficult to get through to someone for advice on the telephone helpline when the midwife running the service was not on duty or was deployed to assist in the labour ward. The helpline was diverted elsewhere, such as to the ADAU or the labour ward at night. This meant that midwives who were often very busy had to answer phones to advise women. We witnessed a midwife answering a phone call from a woman who rang in to ask advice about arrangements for her planned caesarean section. She did not record the conversation. There was a phone call book but the midwife told us that this was completed infrequently.

Maternity and gynaecology

- Women were referred to cancer services through the rapid access clinic, which provided a diagnostic and screening service on their first appointment. The two week target from referral to an appointment at the clinic was met in over 95% of the cases in both 2013/14 and 2014/15. The 62 day urgent GP referrals was below the target of 85%, but had increased from 71% the previous year to over 80% each month between April and September 2015. Performance was better for patients who were referred directly to GSTT, with over 90% of patients meeting the standard in both 2013/14 and 2014/15. Staff informed us that they were working with neighbouring hospitals to reduce late referrals.'
- Gynaecology services exceeded the targets for referral to treatment times. There was prompt access to gynaecology outpatient clinics, with waiting times of less than five weeks. Women's follow up appointments were made on the day of their visit and there were few clinic cancellations. The staff teams were flexible and covered gaps for annual leave to ensure that there was a responsive service. The cancer service met national targets.
- There was a low cancellation rate for gynaecology surgery of less than 8%. When there was a cancellation, the procedure was rescheduled within 28 days.

Learning from complaints and concerns

- The service was responsive to suggestions from women and their families. The Maternity Services Liaison Committee (MSLC) had initiated changes beneficial to the service, for example partners staying overnight on the postnatal ward. This had been instigated by the lay members of the MSLC and had been launched on father's day. Special comfortable chairs had been provided on the postnatal ward for the fathers to rest/ sleep on. This had improved the morale of the women and the staff, especially at night. The service had responded to comments about access to food in the gynaecology ward friends and family test (FFT) by providing a microwave so that patients could heat their own food.
- The monthly performance review scorecard for women's services indicated that 60 complaints were received in the maternity department over the year from April 2014 to March 2015. Most complaints were investigated by 28 days as per policy.
- There had been 15 complaints made in relation to gynaecology services between the period of July 2014 and June 2015. The majority of these complaints included matters related to outpatient services, including clinical treatment, communication and staff attitude.
- Staff were aware of the complaints process. Staff said lessons learnt had been discussed at team meetings.
- Women we spoke with knew how to raise concerns or make a complaint. There were leaflets available in the wards about how to make a complaint. Most women we spoke with said they would raise any concerns with the ward staff rather than make a formal written complaint.
- The service sometimes responded to comments made on the NHS Choices website. The service responded to 38% of comments regarding maternity and 75% regarding gynaecology.

Are maternity and gynaecology services well-led?

Good

Maternity and gynaecology services were working towards achieving the trust's vision and strategy. Staff demonstrated their involvement in projects to drive improvements in patient care through a number of initiatives.

There was a clear governance structure in women's services. There was evidence that gynaecology services responded promptly to identified risks. Some risks had been on the risk register for a long time and although not fully resolved action had been taken to mitigate them.

Staff were positive about working in women's services. There were clearly defined accountability arrangements.

Vision and strategy for this service

- Staff were aware of the trust vision and strategy and identified with the trust's values, namely to: put patients first; take pride in what we do; respect others; strive to be the best; and to act with integrity.
- Women's services' mission was to provide safe, high quality services, to achieve integrated care for women using its services and to have a reputation for excellence in research and education. Their business plan included the objectives of fostering a positive working environment for staff and engaging patients, customers and other stakeholders.

- We observed good communication between board members, senior management and frontline staff. The trust sent staff emails and newsletters to update them on developments.
- Women's services management worked closely with commissioners in developing services for the local population in addition to specialist regional services. There were a number of initiatives to build partnerships with GPs, children's centres and charities with the aim of ensuring the service was organised in the most efficient way. Examples of these partnerships were a domestic violence charity in maternity and an endometriosis charity in gynaecology. The service had employed a patient experience lead to involve patients in the development of the service and in setting priorities.
- The service had carried out research in partnership with King's College London and had applied the results of the research to improving patient care and treatment.
- The service was aiming to make better use of information technology to reduce clinical risk, delays and duplication.

Governance, risk management and quality measurement

- Maternity and gynaecology services had well-developed processes of clinical governance. There were monthly multidisciplinary governance meetings, attended by senior consultant, nursing and management staff. The group received reports from other groups such as risk management, audit, and safeguarding.
- The risk register was an active document, regularly updated, with actions identified to mitigate and to resolve the issues identified. Never the less we found that some risks had been on the register for a long time. The low level of consultant cover in maternity services had been on the risk register since 2010, and although funding for additional posts had been given the posts remained unfilled due to financial pressures. A number of actions had been implemented to reduce the risk of babies not receiving new born blood spot screening since the issue was identified in 2014. However, the risk remained and in June 2015 five babies had not received the screening. The risks associated with the inconsistent response to the telephone helpline had been logged and action taken but the problem persisted.
- The management of maternity services was aware of the issues of capacity with the Antenatal Day Assessment Unit (ADAU) and had taken some action, including increasing the midwifery staffing levels, but problems with meeting demand continued.
- The gynaecology team had taken appropriate action when risk assessments had identified the need for change to improve the service. For example, there was a problem with emergency gynaecology cases. The risk involved had been recognised with regard to delays in going to theatre and delays in senior review of emergency patients. As a result, a business case had been put forward for consultant expansion. This had resulted in three new posts being created specifically to improve care and there was now consultant cover daily for emergency gynaecological cases. The only gynaecology services risk remaining on women's services risk register was inadequate medical cover out of hours. There was a risk that this would lead to delays in treatment for patients as doctors are covering obstetric activity at night. There was a mitigation plan that senior staff would come in if necessary and agreement to recruit. Two doctors in training had been recruited from overseas and there were recruitment plans for the remaining two positions.
- The women's services scorecard was updated each month, and highlighted performance against targets, for example VTE risk assessments, referral to treatment times for gynaecology services, caesarean section rates, and mandatory training. We noted that some items that are commonly reported in maternity services were not included in the scorecard, such as incidents of women with sepsis or occasions when midwives were unable to provide one-to-one care in established labour.

Leadership of service

- The tripartite leadership of women's services (clinical, nursing and management) worked closely together to manage and develop services. Senior midwifery and nursing staff, consultants and managers took part in an event at the end of 2014 to discuss the future of women's services and to contribute to the business plan. There was also multidisciplinary engagement with divisional forums and committees.
- There were strong accountability structures in place. Staff knew who do go to when they needed advice.
- There was good communication with frontline staff through newsletters and regular meetings. Staff

meetings, called 'Spotlight on Safety Days', were held to raise awareness of safety issues amongst staff where incidents and risks were discussed. Patient experiences were also presented and considered. Another aim of the meetings was to support staff wellbeing.

Culture within the service

- Frontline staff were very positive about working for women services and for the trust. They had pride in their work they and were focused on the needs of the women who used the service. They felt supported by their line managers. Staff demonstrated their involvement in projects to drive improvement in patient care.
- In previous years the GMC report on medical training had identified bullying and harassment. As a result, an action plan had been drawn up and the issues regarding the attitudes of staff and support for staff were being addressed. The consultant clinical lead had been attending handovers to help resolve the issues raised. Junior doctors had been encouraged to assist in improving the culture. Two consultants confirmed that there had been problems in the trust of junior doctors feeling bullied by consultants, especially during handovers. Actions had been taken to educate staff in the need to avoid bullying, as shown in the GMC report of 31 May 2015.

Public and staff engagement

- There was an active Maternity Services Liaison Committee (MSLC), which was consulted on issues concerning how the maternity service was provided and had been instrumental in improvements in the service. MSLC lay members were reflective of the local population and users of the service and their views had been considered. The staff groups represented on the MSLC were also culturally diverse. The MSLC had an input into the publication 'Birth Place Decisions', which was produced by Kings College London and used in antenatal classes.
- The 'Hello my name is' initiative was concerned with getting staff to establish more of a human connection with patients. Staff wore 'Hello my name is' badges and introduced themselves to patients when seeing them for the first time.
- Some members of staff took on roles to disseminate information on specific topics and were designated as Women's Champions.
- Regular 'Whose Shoes?' workshops had been held which had involved patients and professionals from 17 disciplines in an informal atmosphere. This provided a forum for discussing salient issues. Each person made pledges to improve their practice.
- There was a 'Roll of Honour' which aimed to recognise staff who had distinguished themselves. 'Letters of Commendation' were awarded to staff identified at risk reviews or through feedback from patients as giving exemplary service. Another similar award was 'Going the Extra Mile'. There was also 'The Marvellous Award' for teams.

Innovation, improvement and sustainability

- Women's services had developed methods of quickly gathering data in order to test initiatives, which they called 'Realtime feedback'. An example was testing improvements to the care of women with chronic hypertension (high blood pressure) who were found to have significantly poorer outcomes of pregnancy than other women. This project has improved outcomes for these women. This work was done within existing resources and staff said they hoped that by demonstrating improvements funding would be allocated to implement the changes.
- Staff took the initiative to gather data and test new ways of working. However, this work, and the audit programme was not supported with additional resource, and staff undertook the work in their own teim. The notes of the governance meeting corroborated comments from consultant staff that responding to risk took precedence over assessing and improving performance through audit. The audit committee minutes were on the agenda for the governance meeting on a quarterly basis, but we noted that this item had been postponed twice in successive meetings.
- The women's service employed 11 professors. There was a professor who led all research projects and there were 15 research midwives assisting. There was one consultant midwife in the research team. The midwives undertook one day a week of clinical work to maintain their skills. 25% of women seen in the antenatal clinic participated in research projects. A patient involvement

meeting was held every Friday. An example of a research project was the development of a swab test to determine if a pregnant woman was at risk of a pre-term birth. This was already in use clinically.

- The community maternity service had plans to set up more postnatal clinics. The project involved determining suitable sites for these clinics. The outcome of this project would determine the number of community staff required. The service was reviewing the existing sites for antenatal clinics and considering the development of hubs such as health centres for the provision of antenatal care. Staff felt the antenatal clinic service could be improved with more staff in order to achieve continuity of care and this would also help with the future plan for the establishment of evening antenatal clinics.

Services for children and young people

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

Information about the service

Evelina London Children's Hospital (ELCH) is part of Guys and St Thomas' NHS Foundation Trust but is housed in a separate, purpose-built building with its own identity as a children's hospital. The 208 bed hospital is a mid-scale children's hospital. It is the second largest paediatric provider in London and covers the whole patient pathway from Community Services (including home ventilation) to emergency care, general paediatrics through to specialist services. 80% of its services are commissioned nationally or regionally. The age range is from birth to 16 but young people up to 19 are admitted for haemodialysis and other planned procedures, a few patients, for example those with learning difficulties may attend the hospital up to age 25. There are 16000 inpatient stays a year, but including outpatients the hospital sees 55000 patients a year.

The inpatient beds are on four floors.A large neonatal unit adjoins the postnatal ward of the neighbouring St Thomas' hospital. It has 16 intensive care cots, 8 high dependency care cots and 20 special care cots. This is part of the South London Neonatal Operational Delivery Network (ODN).The hospital provides a service to the children of Lambeth and Southwark. Lambeth ranks 29th out of 326 local authorities for deprivation (with 1st being the most deprived). Southwark ranks 41st.69% of children admitted to the hospital live outside the local area. ELCH provides a number of specialist regional services in wider networks to the south east region of England including Kent, Surrey and Sussex. The hospital is also a national centre for children's cardiac surgery and performs up to 520 operations and 360 cardiac catheterisation procedures a year. It is also a centre for neuroscience, cleft palate and metabolic services. There were only two specialities where 40%+ of referrals are from local GPs: General Paediatrics and Paediatric ENT.

The hospital provides a range of paediatric elective and emergency surgical services to a national and regional population of children. There are five paediatric theatres, three on the second floor and two on the lower ground floor. In addition there is an interventional suite for heart treatments. There are magnetic resonance imaging (MRI) facilities on the first floor and a positron emission tomography (PET) scanner in St Thomas'. Paediatric ophthalmology takes place in ophthalmic theatres in St Thomas' north wing, with nurses supplied by ELCH. Some complex children's dental surgery takes place at Guy's Hospital, but children's dental procedures are also carried out at ELCH.

Savannah ward is for children and young people with cardiac, neuro-metabolic and orthopaedic conditions. Mountain ward is for general medical, long term ventilation and surgical and high dependency patients. Beach ward is an inpatient ward for children within the specialities of renal and urology. It has a renal dialysis unit and takes children for short stay surgery. Forest ward is a 20 bedded paediatric intensive care unit (PICU), which provides therapies for children referred from all over the UK and sometimes outside the UK.Outpatient clinics and blood tests take place on the ground floor (Ocean level) which has a large reception and play area. The imaging services, heart service, urology and kidney services are on the first floor (Arctic level), which also has a day case centre. Satellite outpatient clinics are also held within one wing of St

Services for children and young people

Thomas' hospital: ear, nose and throat including, cleft and audiology services, speech and language therapies, sleep studies, the allergy clinic and the children's neurosciences centre, the Newcomen centre. These clinics all have their own reception and waiting areas.

The South Thames Retrieval Service (STRS) is run from and staffed by the PICU at ELCH and transports children between hospitals in the South East of England who require intensive or high dependency care. The STRS covers a network linking 22 district general hospitals and three South Thames intensive care units.ELCH also provide outpatient clinics and a day case surgery at University Hospital Lewisham, and doctors hold outreach clinics at hospitals in the network in a number of different trusts across the South Thames region.

During our inspection we visited the neonatal unit, all the paediatric floors, including theatres and some of the outpatient clinics both in ELCH itself and the main St Thomas's building. The inspection team spoke with over 70 members of staff at all levels in the hospital: consultants, trainee doctors, nurses, service managers, administrative staff, porters and domestic staff. We spoke with over 30 families and patients.

Summary of findings

We rated the hospital services good for safety. There was a robust and open process for ensuring that clinical incidents were reported and investigated and that lessons learnt from them were fully shared with all staff. Robust safeguarding systems were in place. Patient risks were appropriately identified and acted upon with clear systems in place to identify and manage a baby, child or young people with a deteriorating medical condition.

We assessed the effectiveness of care provided as good. Substantial participation in national and international audits and research was evident. Care and treatment was provided in line with professional guidance. The hospital was effective at coordinating its multi-disciplinary teams to ensure the best outcomes for patients. While not all services operated seven days a week, services were flexible to meet patients' needs.

We rated the care provided as outstanding. We saw many examples in all areas of the hospital to demonstrate that staff at every level were delivering compassionate care to children in every age group. Parent feedback unanimously supported this. Sensitive emotional support was offered to patients, parents and staff. Parents told us they had a good understanding of the care their baby or child was receiving and that hospital staff involved them in the care their children received. Friends and family test outcomes were highly complimentary of the service. Children and their families were treated with compassion, dignity and respect.

We rated the responsiveness of the service to the needs of patients and their families as good. We found many examples where the hospital and its staff had made special efforts to meet the needs of different groups of children, young people and their families. Examples of initiatives were a fasting reduction initiative for children having surgery, communication boxes on wards to help communicate with nonverbal children or those who did not speak much English, and clinics being timed so secondary school children would not miss too much school. Joint clinics were organised so that young people could meet their ongoing care team to help ease

Services for children and young people

the transition to adult services. Action was in hand to reduce waiting lists and meet the 18 week referral targets for all children and young people but this was not being met in every speciality.

Complaints and concerns were taken seriously. They were responded to promptly in order to achieve resolution. Feedback was actively sought from parents, children and young people about their current care experience, and where possible changes were introduced in response to suggestions.

We found leadership in ELCH to be outstanding. The vision to establish Evelina as a comprehensive specialist children's hospital within a regional clinical network was well understood and supported by staff.

The hospital had a clear clinical governance structure, focused on reducing clinical risk, monitoring quality and improving patient outcomes. There was clear and supportive leadership at local, service and hospital levels, and clear reporting lines for escalating risk, disseminating information and monitoring standards. We found an open and transparent culture with motivated and compassionate staff who were well informed about the hospital's priorities as well as those of the wider trust, and felt they had a genuine role in shaping the development of the hospital. Staff valued the democratic culture. There was an ethos of continuous improvement. Families and patients also felt involved in developing the hospital through consultation and effective communications.

Are services for children and young people safe?

Good

We rated the hospital as good for safety. The service had a robust and open process for ensuring that clinical incidents were reported and investigated and that lessons learnt from them were fully shared with all staff. Safeguarding was well resourced and staff understood their roles and responsibilities and had robust systems for reporting and follow up. Ward areas throughout the hospital were clean and regular hygiene checks took place. Patient risks were appropriately identified and acted upon with clear systems in place to identify and manage a baby, child or young person with a deteriorating medical condition. The nurse to patient ratio was enough to protect children from avoidable harm, and we saw recruitment plans for the neonatal unit to increase the number of nurses to meet the Neonatal Unit expansion.

Incidents

- There had been two never events since April 2015: first, a no harm incident which involved a guidewire not being removed and second, mis-selection of a strong potassium containing solution instead of a saline flush for a 6 month old baby. The baby recovered. That incident was still under investigation at the time of the inspection. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There had been three reportable serious incidents between May 2014 and April 2015. Two were child deaths. Following thorough incident investigations, the findings and lessons learnt were cascaded to all staff by a variety of different methods. These included a one-page summary and root cause analysis report, patient safety messages issued on a weekly and monthly basis and internal patient safety alerts circulated for issues of particular concern.
- Any staff member could report an incident affecting staff or patients through an online reporting system. Staff we spoke with in all areas of the hospital spoke confidently about the process of incident reporting and said there

was no blame attached to reporting. After reporting, incidents were anonymised to protect staff identity. ELCH was a high reporter of incidents. On average 170 incidents had been reported each month between December 2014 and May 2015. In July 206 incidents had been reported, of which 186 were clinical incidents and 20 non clinical. Themes were equipment failures, extravasation injuries and medication errors and proportion of incidents were related to medication, which is common in paediatrics.Risk to patients from medication errors was on the risk register. 97% of incidents had caused low or no harm. Incidents were discussed at clinical governance meetings. A monthly summary of incidents within a clinical area was given to all clinical staff in that area. Key issues were raised at handover and feedback was given so staff could learn from incidents and near misses to improve patient safety. All staff we spoke with said they had received feedback and support, either informal or formal from incidents they had reported.

- Mortality and Morbidity (M&M) meetings were held by speciality. We saw from minutes that there were mortality and morbidity reviews for example, for paediatric intensive care unit (PICU) and Cardiology, the neonatal intensive care unit (NICU) led the M&M process for all neonatal deaths and morbidity with other relevant services such as maternity, anaesthetics and surgery, the General Surgery department also reviewed relevant mortality and morbidity with PICU. In the PICU meetings staff also reviewed child deaths at local hospitals where the child concerned had been in PICU at ELCH. There was a quarterly multi-disciplinary Evelina theatres morbidity meeting led by the paediatric anaesthetists and attended by all relevant medical and surgical specialities. Minutes of meetings were structured and clear. Action plans were agreed from recommendations made and we saw evidence that lessons were shared through presentation at forums, grand rounds, and induction and teaching sessions. All child deaths were reviewed in the monthly clinical governance meetings, as were surgical site infections, serious crash calls and incident themes.

Duty of candour

- We saw evidence of staff training on compliance with the Duty of Candour, both in 2014 and 2015. Staff told us they had had training on scenarios in which the Duty of Candour was required. They understood the need to disclose, discuss and apologise where things had gone wrong and to document this. Staff said that the new duty built on an established culture of apology that was already embedded in their way of working. Staff told us they had experience of or had witnessed the Duty of Candour in action.
- We found that staff were applying Duty of Candour principles in practice.We saw an example where a member of staff visited a family at home to explain what went wrong, and offer an apology for what had happened. A duty of candour letter had then been sent by the clinical governance faciliator and there had been ongoing support for the family through home visits. When the RCA was complete a further meeting would be arranged to offer apologies, provide the family with a copy of the report, and the opportunity for them to ask questions. All incident report forms had a section for Duty of Candour as a reminder for staff to consider this.

Safety Thermometer

- A specific child safety thermometer had been piloted on one ward covering: whether every deterioration in a child's condition had been properly noted and escalated appropriately; extravasation injuries (when fluid from an IV cannula infiltrates the tissues as opposed to staying in the vein, causing swelling, pain and other complications); Pain assessment and management and skin integrity (pressure ulcers and moisture lesions). Staff were considering whether to extend this to other wards.
- Data collected trust wide was displayed in all children's areas. Between April and October 2015 there had been no cases of MRSA bacteraemia, two cases of MSSA bacteremia and five trust attributable case of clostridium difficile (this data relates to all wards in ELCH). All cases were investigated through a Root Cause analysis (RCA). Since June 2014 two pressure ulcers had been reported in PICU in July and August 2014, none since then. One catheter induced urinary tract infection had been reported in Beach ward in January 2015.

Cleanliness, infection control and hygiene

- The hospital had a dedicated Lead Nurse for Infection Prevention and Control (IPC), responsible both to the ELCH head of nursing and the Trust Deputy Director for IPC. An anti-microbial stewardship pharmacist was also

involved in IPC. Clinical staff knew the names of the IPC nurse and their deputy. Link nurses on each ward audited IPC monthly and there were also quarterly checks. Information on IPC was disseminated at weekly meetings, and audit results were emailed to staff. Clinical guidelines had been updated in April 2015.

- A trust wide monthly report including ELCH showed IPC highlights, and contained information on infection rates including central venous line (CVL) infections. All new staff had IPC training as part of their induction. IPC was covered in the one day mandatory clinical staff update. Consultants had a half day mandatory update. 80% of nursing staff had had their annual IPC updates. We checked refresher training on the electronic system WIRED.
- All areas of the neonatal unit, children's wards, and outpatients were visibly clean. Parents spontaneously remarked on the cleanliness of the hospital
- Cleaning schedules for domestic staff throughout ELCH followed NHS standards and used colour coded equipment. High risk areas such as the neonatal unit and theatres were cleaned and audited more frequently (intensive care was audited monthly). We saw environmental audits related to cleanliness which had high scoring results, for example in NICU and PICU the overall cleaning score was 99%, for Beach ward it was 98.4% and for the outpatient areas the score was 98.53 %
- The neonatal unit had its own rigorous system for labelling clean and dirty equipment: clean equipment was bagged and marked with a green label to show it was clean and ready for use. There were appropriate numbers of hand washing sinks in the neonatal unit (NNU) including a non-touch hand washing sink located at the entrance, for staff and visitors to use before entering the unit.
- Clean linen was kept on special linen trolleys. We sampled a range of equipment used by patients such as blood pressure cuffs, slides and tables and these appeared clean. Waste management was appropriate and disposal bins for sharp items were correctly assembled and labelled. Sluice areas were suitably maintained. Staff followed protocols for decontaminating equipment and we saw dated stickers on commodes to indicate cleanliness, and saw that they were clean.
- Single use equipment such as wound dressings, intravenous infusions and suction catheters were readily available.
- Hand hygiene was audited monthly under the '5 moments of hand hygiene' policy: before patient contact, before aseptic techniques, after patient contact, after contact with patient environment and after body fluid exposure. We observed good compliance, generally 100%, and saw that staff challenged each other on hand hygiene. Hand hygiene gel was available in all areas. There was clear signage in public areas directing people to clean their hands using the gel dispensers. Parents we spoke with told us that the nursing staff had shown them how to wash their hands before contact with their children to avoid cross infection. They also told us that the doctors and nurses frequently washed their hands.
- The monthly IPC results were reviewed at the clinical governance meeting. The standard of IPC was generally high and no particular trends were evident. The Neonatal Unit – Infection Control Audit Summary for July 2015 showed that poor performance in central line continuing care hygiene earlier in 2015 had improved significantly between May and June 2015. Published data showed a higher central line infections in neonates (9.2 per 1000 compared to the national average of 2.9 per 1000). The trust were investigating the reasons for this. Likewise peripheral line insertion results were improving and were on the edge of amber range (85-90%). Line insertion remained a key area of focus for the neonatal team even though in a surgical unit line infections might be higher than some other units.
- All staff we saw during our inspection adhered to the 'bare below the elbows' policy, and also used appropriate protective equipment such as gloves and aprons to carry out procedures and personal care.
- There were 28 single rooms that could be used for isolation of infectious patients. Nurses said in winter in particular there were not enough single rooms to wholly prevent a cross infection risk in the event of large numbers of children admitted with different infections.

Provision of adequate isolation facilities during Respiratory Virus Season was on the risk register. Patients with airborne respiratory viruses such as influenza were prioritised for single rooms, and children with droplet spread infections were cohorted. Some children assessed as suitable for management at home were allowed home with arrangements for them to have intravenous antibiotics. Management of children was risk assessed (an isolation risk assessment tool had been developed) and in conjunction with the Lead Nurse IPC, Consultant PID and Virology Doctor. The imminent conversion of the sixth floor of ELCH, currently offices, to bed space would provide additional isolation facilities. Isolation was audited monthly, trust wide and Mountain ward, which took admissions from A&E had averaged 95% the six months since April 2015. Other wards were 100%.

- ELCH scored very well in paediatric intensive care (PICU) audits other than for isolation of potentially infectious patients, because of the limited single room accommodation. In PICU there were three single rooms out of 20 beds.
- Since the start of 2015 there had been 5 Surgical Site Infections (SSIs) in paediatric cardiology, 1 in spinal surgery and 1 in neonatal surgery. Full investigations had been carried out and four were found to have had the same organism. Action had been taken to remind staff of the importance of good documentation and of aseptic non-touch techniques. The hospital had set its own targets to reduce the occurrence of central venous line (CVL) infections, to embed the surgical site infection surveillance process in all areas and to develop a simple risk assessment tool for children and young people at risk of developing hospital acquired infections. Since January 2015 there had been seven needle stick injuries and five sharps injuries.

Environment and equipment

- We saw evidence that equipment was regularly serviced and calibrated. All waiting areas, wards and clinical treatment areas were maintained to a high standard.
- The Neonatal Unit was being expanded to provide 6 additional NICU cots and upgrade four high dependency unit (HDU) and special care baby unit (SCBU) rooms. The unit had remained open during the building work by reorganising some of the accommodation and maintaining tight hygiene procedures.
- Resuscitation equipment was available for children and adults in all areas, and was kept clean and tidy, and records showed it was checked daily. There was a clear documentation template, the Medical Emergency Record, for use in all cardiac or respiratory arrests. The document was kept in the patient's notes and a copy was sent to the resuscitation department.
- Theatre layout on the second floor (Forest) did not fully conform to national standards HBN 26, Facilities for Surgical Procedures and HBN09, Infection control in the built environment. The preparation room and scrub room were shared by two theatres. The inadequate changing facilities for women were on the risk register. Supplies for all paediatric theatres were located on the second floor and some equipment was in corridors because there was inadequate storage. Monitoring equipment had to be moved from the second floor when needed in the lower ground floor theatres or in other areas of the hospital such as the PET scan area. (PET is Positron emission tomography, a technique used to show how body tissues are working).

Medicines

- ELCH had a dedicated children's pharmacy which was open 9.00 -5.30 daily. Out of hours, an adult pharmacist provided cover, with access to an on-call paediatric pharmacist. A pharmacist visited the children's wards daily. We were told that a pharmacist also checked drugs in children's recovery areas, and we saw evidence of this.
- Outpatient medicines for children were dispensed by this pharmacy. Medicines prescribed for patients on discharge were entered by a ward nurse on the pharmacy tracking system and this prompted a pharmacist to visit the ward to screen and dispense the prescription. The turnaround time for dispensing medicine for parents to take away for their child was 60-70 minutes. A pharmacy on wheels (a trolley with a computer and label printer and a locked medicine cupboard below) was used in some areas. This enabled medicines to be dispensed from the ward stock or the trolley.

- Medicines on the ward were managed using an electronic prescribing and medicines administration (ePMA) system called Medchart. This was a new system to ELCH staff although it was used widely elsewhere in the trust. 80% of inpatient medicines were dispensed at ward level. Staff reported that the system was easy to use and provided good support for medicines reconciliation and recording changes in medication, and helped with restocking.
- Medicines were stored in a key coded room, in automated Omnicell cabinets which were linked to electronic prescribing. Medicines could be selected for specific patients by using individual codes or fingerprints to show who took out the drugs. The system enabled easy tracking of expiry dates of medicines.
- Controlled drugs (CDs) were correctly and securely stored and we saw documentation that showed stocks were checked daily. We saw that there were two signatures in the register when CDs were dispensed for a patient.
- Drug fridge temperatures on the wards were all seen to be 5ºC. They were checked and recorded daily. We noted that drug fridge temperatures were not recorded by theatre staff working in recovery but the temperature indicated on the fridge thermometer was correct when we inspected that area. Staff said there was no book for recording fridge temperatures
- We checked 3 medicines administration record charts on the neonatal unit and they were clear, signed and dated, with babies' allergies and weight recorded. There were two neonatal pharmacists.
- Parents were encouraged to be trained by staff to administer their child's medications. Training included the early identification of complications. Parents' competencies were assessed before they were allowed to administer medication without support.
- About 23% of reported incidents were medication errors. The highest error rate was in areas such as PICU where patients were most critically ill and required multiple medications with complex dosing. A root cause analysis was carried out for all medication incidents with ten-fold dosing errors and all incidents in the orange band for severity. The ELCH Paediatric Medicines Safety Forum reviewed themes. In the final stage of a two year project recent improvements to safety had been the introduction of syringes with standardised concentrations of opiates used in paediatrics such as morphine and fentanyl, the use of infusion pumps with smart software to support standard strengths and ensuring prescription charts and infusions were double checked at nurse handover. This project had been acknowledged in national safety awards. In addition training had been arranged for junior doctors to improve prescribing, because wrong dose was the most common error. The training included an assessment of competence.

Records

- Patient information and records were stored securely on all wards. We were told that in the outpatient clinics that patient notes were occasionally not available for clinical staff.
- We examined 10 sets of patient notes on paediatric wards. We found that; pain assessment tools were completed, safeguarding information was present and comprehensive, pre-op checklists were evident where appropriate that included consent forms. The notes showed that early warning scores had been completed and that there had been multidisciplinary input into each child's care.
- Each baby's notes on the neonatal unit were clear and detailed. They were dated, timed and signed, with name stickers on each page. Stamps were used by nursing staff to show their name, grade and registration number. The notes included a pink sheet, updated daily, on which communication with parents was recorded, including what information parents had been given so far.

Safeguarding

- The hospital had Named Nurses and Named Doctors in post as dictated by statutory guidance. There also were safeguarding leads on individual units. Safeguarding teams provided consultation, advice and guidance. Processes were in place to provide safeguarding supervision for staff. A protocol was in place for sharing concerns between agencies where there were child protection concerns.
- Staff we spoke with were fully aware of what to do if they had safeguarding concerns, such as possible non-accidental injury to a child. The hospital policy was

that all paediatric nurses were trained to level 3 (the highest level) and we saw evidence on WIRED that all staff had completed level 3 updates by August 2015. There was also a system to test staff knowledge after they had attended training. A safeguarding newsletter helped keep staff up to date on safeguarding matters.

- We saw that when children and young people were not brought to appointments this was recognised as a potential sign of neglect and followed up in a systematic fashion, involving the safeguarding team. This was part of a wider focus on neglect in the hospital and community. There had been some reduction in the last year, from 15% to 9%, in the numbers of children missing appointments.
- Most children in the hospital were treated in designated paediatric areas. The few exceptions were where children needed to be treated in areas used primarily for adults, because of the need for specialised equipment, for example ophthalmic surgery and some dental surgery. Safeguarding risk assessments were in place and paediatric nurses were involved with patients along with theatre staff.
- We also noted that about twice a month, an adult cardiac patient with congenital heart disease would be treated in the intervention suite. These patients spent a short time in paediatric recovery after treatment, no more than half an hour. This arose because people with heart defects needed lifelong care and were often treated by the same surgeons who had treated them when younger. A corner bay was used for such patients, separated from young people by a hard screen and the adult had one-to-one nursing care. We were informed the normal time an adult patient would stay in recovery was half an hour. A risk assessment had been carried out. From October 2015, a comprehensive refit of the suite would mean this situation would no longer occur.
- The safeguarding policy did not mention the latest national guidance on 'Working together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2015'. However, we noted that training materials on safeguarding did incorporate that new guidance particularly regarding child sexual exploitation. All relevant staff had personal copies of a Quick Guide to Safeguarding, a useful small reference booklet containing key information.
- The hospital had taken part in the Lampard review following the Jimmy Savile investigations. It had introduced training in safeguarding for volunteers, including work experience placements, as well requiring disclosure and barring (DBS) checks. The chaperone policy had also been amended. The Lampard review had highlighted the trust as having a well-resourced safeguarding team. In addition to the annual report on safeguarding, there were quarterly reports to the Board.
- Access to ward areas was secure in ELCH and the neonatal unit. There was swipe card access for staff, with levels of access controlled by the need for access determined by staff roles.Patients and families had to use an intercom, which also had a camera, for admission to wards. We saw an example of a family member being challenged after following a staff member through the door to the ward. An infant and child abduction policy was in place and we saw short, clear action cards for different staff members, such as the nurse in charge, site nurse practitioner and security staff.
- We noted that the guidance on restraint used in managing children and young people , although in line with the last published RCN guidance (2010), would have benefited from taking account of the draft RCN guidance after Winterbourne View , and focus more clearly on principles of protecting human rights and treating people with compassion. Staff told us that they were seeing a growing number of patients with challenging behavior but not necessarily mental health problems. This was on the risk register. The need for clearer practical guidance for staff was clear for the well-being of children and young people. There was a child psychologist on site, but staff reported that the ideal of one to one care in a single room for patients with challenging behaviour was not always achievable.

Mandatory training

- The clinical nurse educator, as part of that role, monitored the training database to ensure line managers kept their staff up to date with mandatory training.
- An electronic system known as WIRED was used to record mandatory training. Mandatory training covered a range of topics including fire safety, consent, emergency paediatric life support, child safeguarding,

manual handling, and equality, diversity and human rights. Most staff we spoke with told us they were up to date with their mandatory training. However, figures showed overall training completion was 82% in July 2015. Staff received advance emails reminding them of scheduled mandatory training updates. Some areas of compliance were high: 99% for health and safety, 88% for child safeguarding (level 3) and 95% for safeguarding vulnerable adults. 94% of nurses had completed basic life support training.

- An induction programme for all new staff included all mandatory training for their individual roles. All new staff we spoke with said they had completed the induction training and had found it detailed and comprehensive.

Assessing and responding to patient risk

- A Paediatric Early Warning System (PEWS), formulated for 5 different age ranges, was used to identify deteriorating patients. The charts had recently been updated so they were colour coded for observations outside the normal range which provided an immediate visual alert without the need for calculation. Clinical escalation pathways were embedded in the chart to make it clear what to do when observations showed a child was deteriorating. The escalation pathway used the situation background assessment recommendation (SBAR) structured method for communicating critical information on a clinical escalation communication form which contributed to effective escalation and increased patient safety. The success of this was being closely monitored, with weekly reviews in which staff were seeking to increase MDT representation. There was clear evidence of increasing early recognition and escalation. There was a slight downward trend in unplanned admissions from wards to intensive care.
- The charts included a section for doctors to set some parameters specific to the individual child and their condition because a number of children had some condition specific issues leading to variance outside the normal range. A review of several charts showed doctors were not always completing this section. The charts had space to record parent concerns over deterioration in their child.There was a PEWS champion and e-learning was available to improve documentation. Simulation training was available for staff using key learning points from PICU admissions in scenarios to promote understanding.
- Nurses we spoke with said they were well supported by doctors when dealing with deteriorating patients.
- Readmission rates to intensive care were within the national average rate. Staff told us their threshold was low for safety reasons because some children had very complex needs. An outreach service for patients discharged from PICU followed up patients within 24 hours. Unplanned admissions were a small proportion of PICU admissions.
- The neonatal unit used a baby monitoring template on which doctors wrote by hand. The handover was judged to be very efficient. It was structured by cot number, new problems, current situation and systems, such as ventilation, cardiovascular issues, fluids and neuro issues. New admissions were discussed in detail, and potential admissions, discharges and transfers were reviewed, as well as information that had been given to parents. Social concerns were discussed where relevant.
- Safety huddles of 10-15 minutes were held on paediatric wards day and night to flag patients at risk and agree a management plan. This initiative was part of the Situational Awareness for Everyone (SAFE) programme led by the Royal College of Paediatric and Child Health (RCPCH). Risk-flagged criteria included patients on high risk therapies, PEWS in red or yellow zones and the first 24 hours of step-down from intensive care.
- A pre-departure checklist was used for patient retrievals from local hospitals to ensure the Retrieval team were despatched to the correct hospital. This had been introduced in response to an incident where the retrieval team had attended a similarly named by incorrect hospital.
- Safer surgery checklists were completed using a laminated wipe-clean board. Observational audits had been carried out to ensure this process was being carried out. A briefing took place at the start of an operating list which we observed in a cardiac theatre. We also saw that ("sign in"), was completed before induction of anaesthesia, then ("time out") before the incision of the skin. Staff told us there would be a ("sign out") before the patient left the operating room which

we did not observe but we saw that ELCH performed well in trust-wide audits for compliance with the surgical checklist: 100% in the cath lab and 97% overall. This was much better than some adult services. in an audit in February 2015.

- All staff we spoke with in outpatients told us they considered the risks to children using the play equipment when attending outpatients to be minimal. Parents and carers were responsible for supervising their children on play equipment.
- Outpatients had an established procedure for the management of patients suspected of having been in contact with Ebola.
- Risks in radiology were understood and managed. Radiation protection monitoring at the hospital was in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Nursing staffing

- The Paediatric Acuity and Nurse Dependency Assessment (PANDA) tool was used daily on the paediatric wards to assess objectively the nursing dependency of children and calculate safe nurse staffing requirements, including skill mix. Staff said that account was also taken of the needs of parents who sometimes also needed care. Expected absences were covered ahead of time by bank or agency cover. We checked staffing records on Husky ward and noted that staffing met Royal College of Nursing (RCN) standards. Management had also used the Integrated Patient Acuity Monitoring System but the results to date had not been sophisticated enough for use at present, and IT staff were urgently working on improvements. A system of 'red flags' was used: a red flag was raised at ward level if staffing was found to be inadequate after patient acuity and numbers had been reviewed. This was done when it was not possible to rebalance the skill mix locally. On only two occasions in the past year had it not been possible to resolve a red flag. Understaffing was only recorded as an incident if levels were detrimental to patient care.
- Nursing had 8% vacancies and 5% of the nursing workforce were on maternity leave. Temporary staff usage was about 7% throughout the year. Challenges exist in intensive care because insufficient nurses are trained nationally. Bank staff were used in preference to agency staff but agency staff were occasionally needed to cover last minute gaps. We saw an induction sheet for agency staff.
- ELCH had a low sickness absence rate of 3%, compared to the England average of 4%. Turnover was at 8% for the year.
- We saw that all children requiring level 3 care in PICU received 1:1 registered nurse support. Those requiring HDU level 2 care were nursed on a one nurse to two patient ratio. The staffing ratios were better than most units according to the Paediatric Intensive Care Audit Network, PICANet.
- When the neonatal unit was at full capacity, neonatal staffing fell below the standards recommended by the British Association of Perinatal Medicine which recommended a ratio of registered nurses to infants of 1:1 for intensive care patients, 1:2 for high dependency and 1:4 for special care. Risk was currently controlled through the use of floating nurses, and we saw business plans that reflected the need to meet these standards.
- Not all neonatal nurses were currently fully qualified in their speciality. However, 70% were fully qualified in line with the national standards for the proportion of nurses who should have post-registration neonatal nursing qualifications. A further 10% were in the process of completing. 94 % were trained in neonatal life support and 43% of these had also completed the national neonatal life support course run by the Resuscitation Council and 72% had mentorship. There were 54 neonatal nurse vacancies due to an increase in the nursing establishment. We saw evidence of a phased recruitment programme including an open day for recruitment planned to coincide with the opening of new cots. It was noted that there is a London-wide shortage of neonatal nurses.
- There were 58 paediatric nurses trained in advanced paediatric life support (APLS). An APLS trained paediatric nurse (an RNP and/or PNP and/or PICU nurse) was on duty in every shift. There was rotational annual training for nurses in paediatric in-hospital life support, intermediate life support and an acute skills course.
- The recovery area was staffed by theatre nurses. On the day we inspected, of 14 nurses on duty, only four were

children's nurses. The other nurses, mainly overseas trained, had completed paediatric competences. On some days this would not meet RCN standards which stated that 'at all times there should be a minimum of one registered children's nurse on duty in recovery areas'. Recovery took place in four discrete areas: in Forest theatre, in Reef theatre, in the magnetic resonance imaging (MRI) area and in the north wing where ophthalmology took place.

- All nurses were expected to mentor new staff and were trained in mentoring.
- Senior Nursing Assistants (Band 3) supported nurses on many wards.
- Nursing staff we spoke with told us that they felt there were enough nurses to keep patients safe.
- Agency nurses had an induction, and we saw completed induction checklists. They came from a single agency and were expected to work for three months at the trust. If any nurse did not meet the standards on their shift they were not reemployed.
- On PICU staffing was supplemented by staff from the Retrieval Service when they were not on the road transporting children. PICU staff were involved in training HDU staff in managing sick children.

Medical staffing

- Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and out of hours, and that consultants were contactable by phone if they needed any support.
- There were three consultant teams covering the Neonatal unit, two for intensive care and one for the high dependency unit and special care unit.
- Staff said medical cover on orthopaedics was sometimes short at night and weekends. Staff told us there were insufficient senior doctors in orthopaedics. The on-call rota was covered by the trauma orthopaedic service which covered children and adults. The paediatric orthopaedic consultants were available for advice and support seven days a week. Additional orthopaedic consultants had been appointed so this was likely to change the current arrangement.
- Junior doctors reported a comprehensive system of formal and informal training, good induction and good mentoring with appropriate support according to their experience. They reported that consultants were approachable at all times, including out of hours.
- Doctors reported that in the neonatal unit 100% of doctors had undergone revalidation by the target date. In other areas there was an action plan to reach 100% within a year.
- All children had a named consultant and there was a consultant of the week for general paediatrics, general surgery and orthopaedics. However, on Mountain, a large 44 bed ward for general paediatrics, paediatric surgery, ENT and HDU consultant names were not seen on all bed spaces.
- Consultants were available to babies on the neonatal unit 24 hours a day, 7 days a week and there was always a doctor of sufficient seniority (ST4 or above) on the ward.

Major incident awareness and training

- The trust had a major incident plan including local emergency resilience actions to be taken in the event of a major incident. Children's services were incorporated in this plan. Staff were aware of the existence of this plan and of its purpose. Fire safety was part of mandatory training which the majority of staff had attended. However some nurses on the neonatal unit were unsure what to do if the fire alarm sounded
- The hospital had trained staff in response to the risk of Ebola.
- The neonatal unit had specific plans for service or equipment failure.

Are services for children and young people effective?

Good

We rated the effectiveness of care provided by medical care services as good. Treatments followed NICE guidelines and new guidelines were systematically reviewed and incorporated in practices as appropriate. The hospital was effective at coordinating its multi-disciplinary teams to

ensure the best outcomes for patients. Pain was being effectively managed and regularly monitored. Nutrition and hydration was being effectively managed. On wards we saw that consent and capacity issues were correctly recorded in patients' notes. Opportunities to take part in research were actively taken up and we saw evidence of some ground-breaking research in allergy and in sleep studies.

Evidence-based care and treatment

- ELCH adhered to guidelines from the Royal College of Nursing and the National Institute for Health and Clinical Excellence (NICE) for the treatment of patients. We saw evidence of systematic and up- to-date assessment of performance against the guidelines, and an effective process for informing staff of guideline changes. The latest versions of NICE and hospital guidelines were available on the ELCH intranet. Staff we spoke with told us that guidance was easy to access, comprehensive and clear. Nurses and doctors were able to find guidance easily on the intranet when we asked them to. Monthly meetings were held to discuss clinical guidelines and evidence based practice. For example a meeting in September discussed protocols including same sex accommodation
- Doctors and nurses on NNU used a mobile phone app called NeoMate which was based upon established guidelines used within the neonatal network. This provided a series of prompts to ensure nothing was missed and also supported the calculation of drug doses, which included infusions. We observed medical staff using this instant access tool.
- Medicines reconciliation was carried out in line with NICE guidance (NG5) and Royal Pharmaceutical Professional Standards for Hospital Pharmacy Services.
- ELCH produces the Paediatric Formulary in conjunction with two other trusts which is a respected source for paediatric prescribing and has just been published in electronic format.

Pain relief

- Children's pain was assessed using recognised methods based on observation (the FLACC scale which is based on observation of a child's face, legs, activity, crying and consolability) or children's own reporting of pain, for example the Wong Baker FACES pain rating scale and we saw these tools effectively used on patients in the day surgery unit. A recent audit showed children were happy with pain relief. We spoke with parents who said the hospital was good at managing pain.
- In addition to ward nurses managing patients' pain, a pain team was also available. Not all children were able to be reviewed daily by this team.
- Patient controlled anaesthesia (PCA) was used according to competence. (PCA is a system that allows pain relief medicine to be given using a programmed syringe pump). Staff were trained in the use of syringe pumps. We saw a child of 9 years old managing this and teenagers were observed using it.

Equipment

- An advanced Neonatal MRI scanner, customised for infants, was co located with NICU which minimised the transfer time for babies needing imaging. The scanner was used for research into normal brain development and its problems, and to test new therapies to treat brain damage. The MRI room had a secure entrance accessible from NICU and the postnatal ward, with a waiting area for parents which had a monitor so they could watch their baby being scanned. An MRI compatible ventilator, Tecotherm, kept infants warm and monitored their temperature, and soothing lights made the atmosphere friendlier. There were daily quality checks to monitor system performance.

Facilities

- The facilities in all areas were child friendly and child psychologists had been involved in the design. In some areas, such as the Newcomen centre, the decor was deliberately minimalist to be calming, and equipment was hidden in consultation areas.
- The catheter lab had advanced imaging capabilities giving high quality and accurate images of blood vessels to enable cardiologists to assess and treat complex heart problems in children. A second catheter lab with similar capabilities was due to open in October 2015.
- The intervention suite equipped with high quality imaging equipment enabled combined interventional cardiology and cardiac surgical work to take place. This made it possible to treat a condition called hypoplastic left heart, which occurs when a child is born with a heart that is not developed on the left side.

Services for children and young people

Nutrition and hydration

- The neonatal unit had a safe system for storing and labelling expressed breast milk. Milk was labelled by mothers, checked by nurses and stored in a named storage area of the fridge. Donor milk was not pooled so it could be traced back through a coded label giving its use by date. The unit could also pasteurise the mother's own milk up to the use by date; 86% of babies discharged from the neonatal unit were receiving some breast milk on discharge which was high; 57% of eligible babies (over 33 weeks) were receiving breast milk exclusively. The national average for babies receiving any mother's milk at discharge was 58%. The milk kitchen conformed to national standards.
- Infant's nutrition and hydration needs were assessed and met through the use of a range of clinical guidelines such as the infant feeding guidelines.
- Breast feeding mothers had access to a breastfeeding specialist nurse and mothers with babies with special feeding needs were able to be referred to the dietician.
- Children's meals were well presented but children did not rate them highly. It was a challenge to meet the requirements of different age ranges, as well as the need for specialised food and cultural choices. There were always snack boxes and fruit available on wards enabling children to eat when they were hungry; for example if they had fasted or missed a meal because of treatment.
- All children with allergies were seen by a dietician to ensure that any nutritional risks were minimised. Every patient who had been admitted was given nutritional screening. Children were weighed twice weekly.

Patient outcomes

- Many of the clinical services provided outcome data to national or international registries. These registries monitor incidence of disease, clinical management of conditions and treatment outcomes.
- There was evidence of participation in a national audits such as paediatric cardiac surgery, diabetes, epilepsy, NNU, asthma and intensive care. For example, the cardiac team used HeartSuite, an online patient monitor designed for cardiology and cardiothoracic surgery which that produces real time information on all aspects of patients' care, and allows comprehensive clinical audit information to be gathered.
- ELCH submitted congenital cardiac surgical data to the National Institute for Cardiovascular Outcomes Research (NICOR) database to benchmark against national practice.A trend in surgical outcomes identified by ELCH staff had led to a comprehensive review and revisions to the programme. When NICOR raised an alert (green flag) a considerable amount of work had been done and after receiving a detailed report said that there was no evidence to suggest that further action needed to be taken (March 2015).
- All potential national audits were assessed for relevance by the trust clinical audit manager to clarify which audits covered the services provided by the hospital. For example, the neonatal unit linked to the neonatal database, Badger, to measure performance against other neonatal units nationally as well as sharing information within the South London Neonatal Network. The hospital provided us with documentary evidence showing action taken to improve patient care as a result of national audits.
- Scores in the 2015 National Neonatal Audit Programme (NNAP) showed: 100% for relevant babies to have their temperature taken within an hour or birth; 87% for mothers receiving antenatal doses of steroids when they deliver babies between 24 and 36 weeks (national standard 85%); 100% for eligible babies receiving retinopathy of prematurity screening (an improvement of 10% from 2013); 84% of babies receiving any of their mother's milk on discharge (national standard 58%) and 83% having a documented consultation with parents within 24 hours of admission (national standard 100%, 89% of hospitals achieve this). The neonatal unit reported all infections in neonates.
- There were 43 local clinical audit projects registered on the GSTT database in July 2015. These included, for instance 'Identifying overweight and obese children which concluded more information needed to be offered to families about the implications of obesity and help with weight management and recommended a

later re-audit.'Investigating reliability and validity of dynamic assessments of language' looking at language in different clinical populations, which led to reflective sessions for speech therapists.

- Audits were also carried out to assess adherence to local policies and procedures such as hand hygiene, consent and record keeping. For example, a consent audit compared ELCH results to the Trust average. ELCH scored higher than the Trust in 9 out of 12 measures but was lower by 14 percentage points in having second stage consent signatures. A similar picture appeared under parent's understanding, but ELCH was lower than the Trust average in ensuring families had enough information to make their choice and in feeling they could change their mind and withdraw consent at any time. A related audit of anaesthetic consent aimed to establish whether enough information about risks was being given to parents in the light of a recent court case (March 2015) that had changed English law. The action from this was to ensure more information would be provided and all key points told to parents should be documented.
- A pre-surgery pregnancy testing audit found that the test was generally carried out but that more information should be given, including documentation of the test, information and consent. An action plan with named responsible people and timescales set out plans for awareness raising and a plan for re-audit.
- The children's allergy unit, the largest in Europe, was an integrated academic and clinical unit undertaking research in common child allergies such as nuts and asthma. Performance in the paediatric asthma audits showed fewer multiple admissions (12.4%) than the national average (16.9%).
- 25% of the trust's research contacts concerned children. The research team supported over 70 studies and a number of children were participants in clinical trials to develop new treatments. The hospital was participating in 25 trials of medicines in children.Examples of other research projects were NEUCHILD neurodevelopmental disabilities sleep study, the UK ChiMES meningitis and encephalitis study, FibCon Heart services study focused on children whose blood does not clot properly and the HOT-KID chronic kidney disease study.
- We observed the clinical practice of a number of play therapists that followed good practice. Clinical staff told us that the play therapists were effective and they were available when needed; for example when a child needed to be distracted from a difficult procedure, such as taking a blood sample.
- On the PICU Specialist Service Quality Dashboard (NHS England) ELCH was about the national mean or better for its refusal rate for emergency admissions,cancellation of elective surgery due to bed availability and emergency readmissions to PICU within 48 hours. It was in the better than expected range for risk adjusted mortality.We noted there had been a rate of accidental extubation of 0.51% in the quartile, which was slightly higher than the national average of 0.45%. Data on the service was submitted to PICANet. The data in the 2015 report showed that the unit had better staffing ratios per bed and more middle grade doctors than most units.
- On the Inherited Metabolic Disorders Specialised Service Quality Dashboard (NHS England) was within the expected range for all indicators and significantly better for reporting of Phe monitoring blood results.(Phe is Phenylalanine, an amino acid an excess of whichis dangerous to the developing brain of children with a specific genetic disorder).
- Neonatal cot occupancy was close to the England average and the unit performed at the national average on most domains in the National Neonatal Unit Programme summary report.
- ELCH performed slightly worse than national averages in the Paediatric Diabetes Audit (2012/13) but scored higher on screening for thyroid function and for coeliac disease.
- Audits were presented at Evelina Quality Improvement Conferences, speciality meetings, and weekly Grand Rounds to raise their profile and generate discussion. Many staff we spoke with aware of the findings of audits in their areas indicating that dissemination was effective.
- The South Thames Retrieval Service closely monitored its service against national averages; for example its mobilisation times and refusal rates. These were submitted to PICANet. Performance indicators were

clear to staff and published in a quarterly governance report. 95.5% of all referrals requesting South Thames admission could be accommodated within the network which was well above the national average.

Competent staff

- Newly qualified nurses underwent a preceptorship that involved acquiring specific competencies and setting career objectives. This meant that although they counted towards the ward staffing numbers, they were in a protected environment which supported their training and development.
- Senior Nursing Assistants (SNAs) had an initial induction period of training and practice covering basic care, washing, feeding, and resuscitation. They were clear about their role and were not asked to undertake inappropriate duties for which they were not qualified. We found that a number had received further development training; for example in taking blood or in tracheostomy care.
- All staff were required to have an annual appraisal covering a review of their individual performance and also a formal review of mandatory training completion. In July 2015 78.8% of staff across all areas of ELCH had received their annual appraisal. Some areas had higher rates for example in PICU the rate was 89%. We spoke with clinical staff who told us they had annual appraisals. They also told us that handovers, ward rounds and team meetings provided them with regular learning opportunities. Staff from different wards and departments told us that there were opportunities for courses and study and rotation opportunities for gaining experience and competencies.
- A junior nurse in the neonatal unit said she had had to chase her manager for an appraisal. Staff generally reported that appraisals were useful and made things happen, such as training opportunities. Staff spoke favourably about the availability of ways of teaching to support learning styles: e-learning, workshops, on the job training, mentoring and coaching.
- We spoke with trainee doctors who said they were well supported and that the hospital was a safe place to work. Teaching was supported and changes to guidelines were cascaded down through email, meetings and newsletters.
- Individual staff were responsible for maintaining their Nursing and Midwifery Council (NMC) registration. There was a central reminder system underpinning this.
- Prior to employment newly qualified nurses attended an assessment centre to check their numeracy, literacy and understanding of infection control. They received a Knowledge and Skills Framework (KSF) folder to start to maintain a continuous review of their skills and experience. The nurses then followed an 8 month rotation through three wards, as part of which they did a medicines management test, an intravenous therapy test and learnt intermediate life support skills. There was a capabilities pathway for those needing additional support. Link nurses for students provided support for newly qualified nurses.
- The 'Big 4' was a simple and effective monthly mechanism for achieving ward staff focus on inpatient issues relating to the standard of care; for example secure entry to wards and documentation storage. The four areas of focus for the month were communicated by email and displayed on notice boards
- Staff were encouraged to develop their skills and knowledge such as by attending conferences and other continuing education.
- Coaching skills training was available for those at Band 6 or over.
- Paired learning had been set up to allow, for example, doctors and managers shadowing each other to extend experience across professional boundaries.
- The Clinical Nurse Educator (CNE) network was also involved in overseeing the pilot for the new nursing revalidation scheme in preparation for the national roll out in 2016 designed to strengthen the three yearly registration renewal process and increase professionalism. From the pilot, the CNE was estimated that some 7% of nurses might need support in providing an up to date portfolio, demonstrating reflective practice and evidencing 150 hours of study time in the preceding 3 years.
- Pharmacists contributed to teaching doctors about paediatric prescribing and in examining doctors in

RCPCH assessments. They teach in the Paediatric Pharmaceutical Care International Master Classes and train nine pharmacists a year on Paediatric Pharmaceutical Care internships.

Multidisciplinary working

- ELCH had dedicated physiotherapists, psychologists, dieticians, occupational therapists, play therapists and pharmacists. Throughout our inspection we saw evidence of good multidisciplinary team (MDT) working throughout our inspection in the wards and clinical areas. The monthly 'Evelina forum' involved medical staff, nursing staff and allied health professionals. Clinical staff told us therapists in all disciplines, nurses and doctors worked well together. Mortality and morbidity meetings were held fortnightly and there was a quarterly multidisciplinary surgical/anaesthetic morbidity and mortality meeting where cases were discussed, recommendations were made and actions were assigned.
- Pharmacists checked medicine charts daily and recorded the checks, and also signed that they had checked fluid charts.
- Multi-speciality meetings were also held; for example for pre-operative planning and for taking decisions about the treatment of complex conditions in fields such as haematology, the respiratory system, neurology, anaesthetics and orthopaedics.
- Weekly MDT meetings were held to review patients with complex conditions on Mountain ward and we saw evidence of MDT involvement in ward rounds. We observed a cardiac MDT meeting which was well organised and chaired by a consultant. There were clear presentations on each case and high quality discussions leading to a plan. There was a video link with a paediatric cardiac service in Northern Ireland.
- Ten play specialists worked across most areas. There was not always a play specialist in the outpatient department but they were on call. A play manager, a new post, was about to be appointed. The play team were pleased that this role has been recognised as necessary to manage the work load effectively.
- Nurse and doctors on the neonatal unit shared the same handover sheet which was good practice as it enabled all staff to have the same information and avoid potential gaps in information about neonates.
- The neonatal unit staff met weekly with the fetal medicine unit to consider babies expected to require admission. The unit held a list of expected babies who would come into the unit, filed by expected date of delivery and gestational age together with their ultrasound reports..
- Some children's clinics such as allergies and sleep studies were under the adult Genetics, Rheumatology, Infection, Dermatology and Allergy (GRIDA) department of the hospital but staff had close links with ELCH. For example, when children stayed over for sleep studies the Paediatric Nurse Practitioners (PNPs) on duty in ELCH at night would be aware. Both sleep studies (2 beds) and allergies had children attending as inpatients as well as to clinics. The sleep inpatient unit was the only specific in patient sleep study unit in England.
- We found that hospital psychologists were able to provide support to staff, families and patients.
- Outpatients and diagnostic imaging departments supported multiple speciality clinics. Staff told us that effective multidisciplinary working assisted with communication when transferring children between different services. The parents of a young person with complex needs told us that they were very happy with the way various specialists had worked together to provide treatment.
- Weekly psychosocial meetings considered the additional support needs of some families.

Seven-day services

- Sunday surgical activity was confined to emergencies. Some theatre lists were run on alternate Saturdays. When the hospital made new medical appointments there was a contractual requirement for Saturday working. Operating lists normally stopped at 4.30, sometimes at 6.30. Later lists would have created difficulties for families.
- Early evening clinics such as in rheumatology reduced the amount of school missed by teenagers. Saturday renal dialysis was available to young people for the same reason.

Services for children and young people

- The radiology department provided 24 hours on-call services.
- The staffing at night at ELCH comprised two registrars, two SHOs, and a surgical and a general paediatrician. Two paediatric nurse practitioners were also on site. Aside from the handover at 8.30pm there was also a safety huddle, chaired by a PNP, to review all patients flagged as at risk. A paediatric cardiology registrar was on call but off site. The paediatric consultant was on site until 10pm.
- The outpatients department ran from Monday to Saturday.

Access to information

- There was evidence that guidelines and protocols were accessible to clinical staff, including the Trust antibiotic policy, Medusa for children (a database on the administration of intravenous medicines) and local guidelines.
- Staff were positive about the electronic patient record system. They reported there were no delays in accessing patient information.

Consent

- We found that consent to treatment for patients was obtained following correct procedures. All staff we spoke with were aware of the trust's consent procedures and all understood their role and responsibilities when obtaining consent.
- Families and carers were involved in discussions about consent. We found that staff were aware of and able to describe how consent issues changed as children became older and were more able to make their own choices.
- At the pre-admission consultation before surgery staff assessed whether a child was mature enough to make decisions about their care and treatment, using the test of 'Gillick competence''. This ensured children could make their own decisions when they had sufficient understanding and intelligence to be capable of making an informed decision. Staff we spoke with fully understood the Mental Capacity Act 2005 as it related to consent to treatment.

Are services for children and young people caring?

Outstanding ☆

We rated the care provided as outstanding. Staff demonstrated passionate commitment to providing reassuring and holistic care to the child as well as to family members, including siblings. Staff made considerable effort, in some innovative ways, to understand the views of children of all ages, and their families. Staff drew on this information to make changes, where necessary, in ways that improved the experience of patients and families.

In every area we inspected we saw hospital staff from domestic staff to doctors talking warmly to children and their families. Parents unanimously reported that children and young people were positive about almost all aspects of their time in hospital, and felt staff understood the stress on them as parents of sick children, as well as the stress on young patients, and offered sensitive emotional support. Parents told us they had a clear understanding of the treatment their baby or child was receiving and that nurses helped them to become involved in their child's care. The friends and family test outcomes showed families were highly complimentary about Evelina Children's Hospital. Internal hospital feedback supported this. Children and their families were treated with compassion and respect.

Compassionate care

- Throughout our inspection, on the wards, in outpatients and in the neonatal unit, we observed patients and families being treated with patience, kindness and understanding. The families we spoke with were impressed with the care and attention of staff. They told us doctors, nurses and other hospital staff were all proactive in offering help, ready to listen to them and responsive to any concerns. Many families had experience of other hospitals. These parents rated their child's experience of care at ELCH as well as the support that staff gave families, far more highly than experience at their local hospitals.
- Parents of children in the neonatal unit were unanimous in their praise for the care their babies received. Parents said staff "were brilliant" and they "could not be happier", "everything is done so well". Staff were said to

be “friendly” and “very transparent and honest”. Parents told us that staff looked after parent's needs and worries, as well as those of their child. Staff told us that when they were aware that parents needed support at a particular time, they could take account of parent needs in ward staffing. We observed nursing staff communicating with parents of babies with complex conditions calmly and with empathy.

- Parents and relatives told us they found staff were open and approachable yet they always remained professional. They said they felt confident about staff's skills and knowledge and felt privileged to have staff support in helping them care for their child..
- All the children we spoke with considered that nurses and doctors were friendly and helpful, and had time to listen to them. Curtains were drawn to give children privacy and maintain their dignity when being examined or treated..Children said nurses always responded promptly if they felt any pain or were worried about anything,
- We saw excellent age appropriate interactions between staff and individual children in all areas. In many cases it was clear that staff had got to know individual children and families well.
- To the core Friends and Family Test (FFT) question ‘How likely are you to recommend our ward to friends and family if they needed similar care or treatment?’ the hospital performed very well, with over 90% of respondents in every area saying they were likely or very likely to recommend the hospital. Everybody said they would recommend the care provided by doctors and nurses. The hospital would have liked a higher rate of response from patients but responses were well over 30%. The Friends and Family Test was only one of a number of ways that ward staff gained feedback from children and families. Parent and child participation in internal ways of gaining feedback, gave staff a rounded picture of child and family satisfaction with the service
- ELCH had won an award for its response to parent experiences with babies in the neonatal unit. A project on kangaroo care for neonates had increased opportunities for parents to experience skin to skin contact with their baby and so ease the distress of separation and encourage bonding. Reclining chairs had been provided for parents and ward processes had been changed to allow mothers and fathers more uninterrupted time in the evenings with their baby. Fathers particularly appreciated this as they were not always able to visit their baby during the daytime.
- Staff arranged pre-admission visits to help children understand better what coming onto a ward or for day treatment would be like. During our inspection we observed a successful example involving a child with autism. The parent was pleased that their child had been relatively relaxed in the hospital environment because they had visited a few times before the treatment day.

Understanding and involvement of patients and those close to them

- We saw nurses, doctors and therapists introducing themselves to patients and their families, and explaining what they were going to do. During consultant ward rounds we observed doctors talking directly to children and also making time to speak to parents and offer opportunities for them to ask questions.
- Doctors and nurses in both the neonatal unit and the paediatric wards had daily contact with parents. Parents told us that doctors took time to explain test results and their implications, and the side effects of any medication, in ways they and their child, if old enough, could understand. Parents could speak with staff in private if necessary. Older children could speak to their consultant without the parent present if they wished.
- Young people told us doctors and nurses involved them "as much as they wanted" in decisions about their care and treatment, and talked with them using language they could understand and listened to what they had to say. Some said it felt daunting to move to adult services but they, and their families, reported being pleased with the arrangements for transition to adult clinics and the opportunity to develop a relationship with staff working mainly with adults.
- All parents we spoke with said they valued the readiness of staff to listen to them, and even record their views in their child's notes. They said staff recognised that " parents are the experts on their child" in some ways. Parents and relatives said staff encouraged them to ask questions, and made them feel at ease in doing so.

Services for children and young people

- The 'Tell us' initiative gave staff real time feedback on parents' views about a ward. Play specialists also worked with parents to encourage discussion and feedback.
- Mothers in NNU said communication from all clinical staff was excellent. They felt staff were clear and honest about the condition of their baby. Staff made time to ensure parents' understood the treatment plan for their baby and the implications of diagnostic tests.
- Staff trained children who self-administered their medicines, such as children who had had a transplant and those with chronic renal failure for whom compliance was very important, so they could pack their own "Dosette" packs and identify their individual medicines to facilitate dosage adjustments. One adolescent said this helped them feel 'in control'.
- Staff facilitated support groups for children and families with chronic conditions so they could share experiences with others facing similar issues.
- A pharmacist attended the weekly clinic for paediatric HIV patients to give counselling on medicine use. The clinic was considered a more appropriate setting than the children's pharmacy area, where space for private or sensitive conversation was limited.

Emotional support

- Staff demonstrated an understanding of the parents' and children's situation and worked well to lower people's anxiety, speaking to them in a kind and empathetic manner. For example, on wards and in outpatients play therapists were available to calm and reassure children who were upset or anxious and to distract them during procedures.
- Staff demonstrated a good understanding of the triggers for people's emotional behaviour, particularly frustration or aggression. We observed a nurse using calming techniques with a mother who was upset.
- A counselling team was available to support parents who had an ill or chronically sick baby in the neonatal unit or child in the hospital. Parents could refer themselves or, with their consent, be referred by staff. Support was also available through the multi-faith chaplaincy which was available to anyone whether they had a religious belief or not.
- Parents with a baby in the neonatal unit were provided with emotional support from the whole inter-professional team to enable them to cope with their baby's treatment and any long term care needs. The family's needs were discussed at the weekly MDT meeting, which was attended by the clinical psychologist, the chaplain and the social worker. Staff across the Evelina offered sensitive support for parents in the event of death.
- Bereavement arrangements for families whose children had life-limiting conditions were flexible and supportive. Early introduction to palliative care ensured children and their families were given the choice about whether they wished to receive end of life care at the hospital, at home or in a hospice and staff helped them achieve their choice. Individual care plans were regularly reviewed by staff with the young person and family. Staff took account of individual circumstances and needs and supported families in their decisions, without judgement. The team offered effective symptom management and their services, which also extended to include outings for patients and families.

Are services for children and young people responsive?

Good

We rated the overall responsiveness of the service as good. Some elements were outstanding, such as the special efforts made by staff to identify and meet the needs of a wide range of different groups of children and families, by language and culture as well as by medical condition. However there were challenges in referral to treatment times and there were insufficient single rooms for adolescents and for children and young people with infections. Staff were working on improving referral times and the accommodation needs were reflected in future building plans.

Systems and initiatives were in place that ensured children's' individual needs were being met. This included a fasting reduction initiative for children having surgery, increasing accommodation for parents, communication boxes on wards to help communicate with nonverbal children or those who did not speak much English, and clinics being timed so secondary school children would not

miss too much school. Joint clinics between child and adult services were organised across all services so that young people could meet their ongoing care team to help ease their transition to adult services.

Demand for ELCH services was growing each year. Waiting lists for outpatient appointments and surgery in some specialities were over the 18 week target. Overall 81% of children and young people were seen within the target period. Staff were actively making changes to reduce the backlog through appointing more consultants, reducing the number of times some children needed to attend the hospital and improving theatre utilisation and maximising utilisation of clinic space.We saw action plans and plans to monitor progress. There was some evidence that waiting lists were beginning to reduce in some areas. In 2016 six paediatric and long term ventilation beds were planned and in 2017 there would increased capacity for acute and NICU beds

Complaints and concerns were taken seriously. Staff responded promptly to formal and informal complaints so families did not have to wait long for resolution. We saw evidence of improvements to the quality of care in response to complaints, as well as to suggestions from families and staff. Feedback was sought from parents and young people about their current care experience and where possible changes were made.

Service planning and delivery to meet the needs of local people

- The service catered to needs of children and young people locally in Southwark and Lambeth as well as the to needs of a much wider population group**.** 80% of commissioned services specialist services were for a national or regional patient population. After treatment children were discharged back to the healthcare provider who had referred them, although for some the care continued to be shared between ELCH and local hospitals and clinics.Staff liaised with the local community team or acute trust prior to a child's discharge.
- Staff were very aware of the different needs of their diverse patient group and their families. They were able to describe how they met different needs, for example, children and young people with learning disabilities, babies, teenagers and physically disabled patients.
- 140 languages were spoken in the local area. Language support was available in the form of face-to-face interpreting, telephone interpreting and written translation. Interpreters were used in preference to family members. Colours, symbols and themes were integral to the design of the hospital. The symbols were child friendly but also helped families who did not speak or read English.
- An informative and easy to navigate website provided information for families and patients on many topics, and included virtual tours of different floors so that families could familiarise themselves with the layout. Some parts of the website were designed specifically for children, young people and families. Information for parents on the wards showed numbers of staff on duty that day, photographs of ward staff and safety information, and 'You said, We Did'information showing the ward's response to recent suggestions from families.
- Parents could stay with their children at all times in paediatric wards. There were kitchens on wards and several cafes within the hospital. One parent could stay overnight on a pull down bed alongside their child.
- For parents of children and babies in intensive care short term accommodation was available in nearby Gassiot House, on the St Thomas's site. The neonatal unit had three rooming-in rooms where parents could stay when preparing to go home with their baby or when a baby was admitted from a distant hospital. Other parents could be accommodated near Guy's Hospital. As parent accommodation did not meet demand, more was being built.
- A well-equipped hospital school operated during term time. This had been rated Outstanding by Ofsted in 2013. Staff taught about 1500 children and young people aged 2 to 19 each year, some regularly such as those on dialysis. The school was able to support young people taking examinations including older young people who had been admitted to adult wards. Pupils too unwell to leave the ward could have one to one education by the bedside, and all were supported to complete work sent electronically by their home schools.Siblings sometimes attended the school. The school had links to Southwark Local Authority's home tuition service.

- During a period in intensive care, both in NICU and PICU, patients were allocated to the consultant of the week. Parents in all wards said they had frequent opportunities to speak directly with their child's consultant, and generally knew them by their first names.
- Parents told us they received copies of correspondence between the hospital and their GP which they found helpful. Hospital staff also gave them written information about their baby or child's condition to complement face to face information and discussions.

Access and flow

- During our inspection we observed that there was a good flow into, and out of, the hospital and between the wards. Some wards had capacity to take new patients. There was an effective bed management system that ensured that managers had a clear picture of demand and capacity at any given time, so when a bed was needed in an emergency the hospital was able to respond quickly. When PICU activity was high, 'ability to admit' criteria were used, alongside the Trust staffing escalation policy, There was some capacity to flex the number of beds in intensive care by using respiratory or cardiac cubicles. We saw no examples of delayed discharges from intensive care. The hospital worked with other local trusts to accommodate discharges from PICU during the winter peak period.
- The hospital offered numerous different day services so that children could avoid admission. For example, patients came in as day patients for blood transfusions, renal dialysis and tests requiring sedation.
- Efforts had been made to prevent hospital admissions by consultants providing advice to GPs on managing patients. A hotline for GPs, known as the Children's acute referral service (CARS) was available between 11am to 7pm. It also offered prompt email advice and rapid access to outpatient clinics to reduce emergency department attendance. This service had been in place a year and its use had grown. A new Paediatric Assessment Unit was due to open in the emergency area to improve patient flow.
- Overall the backlog of patients waiting over 18 weeks had been around 80% throughout for the year to August 2015. The biggest challenges were in cleft palate, orthopaedics, spinal, ENT, plastic surgery and endocrine and diabetes, where only 70% of patients were seen and treated within the target.
- There were pressures on outpatient clinics. In 2014-5 there were 61,623 children and young people on the waiting list. This was expected to rise to 65000 in 2015-6. A number of clinics, such as respiratory physiology exceeded the 18 week timescale for accepting referrals. The average wait for this clinic was 23 weeks. Some patients were awaiting specialist treatment for severe, rare or complex disorders, such as kidney transplant or heart surgery where there were limited options for treatment elsewhere.
- Waiting lists for ENT patients were growing because of the trend to refer children to specialist centres. ENT had seen a 20% increase in a year. In response two additional consultants had been appointed which was expected to reduce waiting times significantly. Clinic staff sought to manage families' expectations by clear communication of waiting times for appointments.
- Work had already taken place to streamline the outpatient experience for families. In the main outpatients department (Ocean) a system had been introduced to reduce queuing to check in, and to speed up the process of weighing and measuring children. 12 volunteers helped families to find their way around. This had led to measurable improvements in patient and family satisfaction.Other improvements planned were opening more clinic rooms, standardising booking processes between specialities, validating waiting lists regularly, and arranging cross cover for leave and sickness to avoid clinic cancellations.
- Staff tracked clinic waiting lists every week, by speciality, to identify bottlenecks. Combined hospital and patient cancellations averaged 15%. The target was that the hospital should reschedule fewer than 5% of clinics. Currently rescheduled appointments were higher in orthopaedics, cardiology and paediatric urology and staff were investigating the reasons for this..Patient cancellations averaged 10% but were as high as 20% in some specialities such as metabolic disease, endocrinology and respiratory system. Text messaging was used to remind parents of appointments to help reduce the number of missed appointments. Consideration was being given to using Skype and

telephone appointments to follow up relevant patients and reduce the number of patients needing to travel to the hospital. More weekend clinics were being run. There was evidence that these measures were beginning to reduce waiting lists.

- A surgical productivity strategy had been developed to seek to reduce delays and cancellations and ensure more recycling of cancelled lists. Elective surgery was 12% behind plan at the end of May. Rich data on theatre utilisation opened up possibilities for improving flow through theatres and for reducing the backlog. Utilisation was about 85% in winter and 75% in summer. Theatre staffing, which was not provided by the children's service, was a constraint on better utilisation. An audit had shown that following a bank holiday at least one theatre had been empty all week which was not acceptable given the shortage of capacity. Staff were seeking to manage staff leave better to ensure cover for theatre lists when a doctor was absent. Some 1-2 cancellations a month were due to consultant absence and that should be avoidable. Patient cancellations were also a problem: for example,595 patients had cancelled in July.
- The percentage of cancellations on the day of surgery, usually because of a lack of PICU or ward beds, was better than the national mean of 6.6%. Overnight intensive recovery beds had been piloted in 2014 and were expected to reduce patient cancellations in future.
- To reduce the backlog of patients waiting more than 18 weeks for surgery in areas such as cardiology and orthopaedics, consultants were now reviewing all external referrals to ensure that ELCH only accepted appropriate cases. The hospital had made arrangements for some patients to have surgery at other London hospitals with paediatric capacity, both private and NHS. These activities were helping reducing waiting times for surgery, as there was limited scope in the medium term to increase bed or theatre capacity.
- Neonatal cot occupancy had been close to the England average for some years. In 2014/15 the neonatal unit treated 927 neonates. Nurses told us that occupancy had risen by 8% in 2015. Most referrals were from within the wider neonatal network; only 10% of babies were admitted from the trust's maternity unit.There had been a 7% increase in referrals from within the network and 193 refused referrals because of a lack of capacity either in the NNU or in the maternity department.
- The median length of stay was higher than the England average for patients under one but in line with the average for older children.
- Readmission to hospital within 48 hours of discharge is a National performance indicator. Non- elective re-admission rates (3%) were lower than the England average for children and young people of all ages. In cardiology, elective admission rates were lower for babies under 1, but re-admission rates for children over one were higher than the national average.
- ELCH runs the South Thames Paediatric Retrieval Service, a children's acute transport service which specialises in the inter-hospital transfer of critically ill children in London (south of the River Thames). A PICU consultant was also the Regional Retrieval Lead. Up to 40% of children on the PICU were admitted from other hospitals. The hospital could accommodate most retrievals by applying a flexible approach and occasionally using recovery beds for overspill, as a last resort.

Meeting people's individual needs

- Good provision was made for patients with learning disabilities. Makaton (a language using gestures and pictures) was used as appropriate. There were communication boxes on wards to provide other resources. 'Sing and sign' was used daily by play therapists to communicate with children with sensory deprivation. Staff were trained on working with patients with autism
- There was a very good range of play equipment throughout the hospital. Play specialists were available in most areas, although nurses felt that more play specialists would be useful. For inpatients there was a weekly Scout and Guides Unit for 6-18 year olds which organised a range of leisure activities.
- There were separate areas on some floors for adolescent patients. These were well equipped with media equipment, books and posters. Some clinics for adolescents took place in the early evening, after school. We saw there were comprehensive information

leaflets in relation to transitional care including 'Transition to adult services for children with a learning disability'. There was a young person's Forum on quality care for adolescents.

- Transition to adult services began at age 11 or 12, and patients in their teens gradually moved to attending clinics alone, meeting clinicians within the adult service. Part of the appointment coukd involve the parent if the young person wanted that, Each speciality arranged their transition clinics separately, but followed a broadly similar pattern, and all had a champion for transitional care. Before young people were ready to move to adult clinics they attended joint clinics with joint documentation. Transition clinics were held in the early evening to minimise time off school. For example, we saw an evening clinic, run jointly by staff from adult and child allergy services, for young people with complex allergies that would require continuing management into adulthood. The transition clinics offered longer appointments (45 minutes) to help young people become used to attending on their own, and to allow young people the opportunity to talk about wider health issues related to adolescence, if they wanted to do so.
- Young people were encouraged to be pro-active in their own long term care. ELCH had developed and published a teaching programme to support adherence to lifelong medicines needed to prevent transplant rejection or disease progression. Parents were also asked what information they wanted to receive about their child's medicines.
- The neonatal unit was part of a pilot using resources from the Small Wonders project to support parents with sick and premature babies to be at the centre of their baby's care in ways known to improve health outcomes. An expressing room with breast pumps was available in the neonatal unit.
- An outreach team supported transition from the special care baby unit to home. This team had been set up to improve flow and follow up of discharged patients. Staff liaised with the long term ventilation team, as needed. Currently there were four dedicated long-term ventilation beds on Mountain ward.
- For parents who had lost a baby that had been cared for in the neonatal unit, the hospital provided a quiet room with homely furnishings and a 'cuddle cot' with a cold mattress which meant there were no time restraints on how long they could stay with their baby. Bereaved parents were offered mementoes with photographs and hand and foot prints. Those who wished could see their child in the Chapel of Rest. Transfer of a baby to the morgue was carried out in a sensitive and dignified way. Parents who suffered the loss of a baby were given information and contacts who could offer additional support.
- Staff were tackling the problem that children had sometimes fasted too long when awaiting surgery. A fasting champion was nominated from the theatre team. The 'champion', once the theatre list was fixed, would notify the ward so children later on the surgical list could be allowed to drink. This person also notified the ward of any unexpected delays which could extend the period during which the child could have a drink. Snack boxes were available so children could eat as soon as they were ready after surgery
- Focus groups and forums for parents had been set up around different conditions, for example a Down's syndrome family focus group, a Renal Parent's forum and a sickle cell group. There were also groups for children and young people, such as a group for 10-14 year olds with asthma. We saw Information displayed on dedicated notice boards for particular conditions e.g. sickle cell disease, as well as information folders in specialist clinics e.g. allergy to supplement information passed on during appointments.
- ELCH clinical staff worked with the local Children and Young People's Health Partnership to make services more seamless between hospital and community. For example workshops were being held for Latin American mothers in Spanish to help them understand what to expect of the healthcare system.
- An outpatient antibiotic therapy service was being set up with pharmacy support to that children needing regular antibiotic treatment could be treated at home rather than in hospital, or would need to make fewer visits to the hospital.
- Smoking cessation was offered to patients. When a young person was offered help to stop smoking, a similar service was offered to their parents.
- Families and young people were encouraged to comment on their experience in the hospital so that

services could be improved. They were also involved in future plans.For example, former and current parents of babies in the neonatal unit had participated in virtual,and actual,meetings about the design of the extended space to meet families' needs better. Families were kept up to date about future developments on which they had commented using a range of presentation formats, through Facebook and e-bulletins, and sometimes video.

- In all waiting and clinical areas we visited we saw that bespoke information about services and treatments was readily available in print form. Also on display on wards and in clinics was information from other organisations such as BLISS (neonatal), Allergy UK (paediatrics) and other charities concerned with medical conditions. All the hospital's leaflets were also available on the website.
- The ELCH palliative care service was available five days a week 9am to 5pm. Links with another children's hospital enabled families to benefit from a 24 hour, 7 day service, both in hospital and at home. There were links to a children's hospice. The service covered greater London, Surrey, Sussex, Thurrock, Medway, East Sussex and Kent. The demand for this service exceeded current capacity so the hospital were recruiting another clinical nurse specialist (CNS) and expanding the general paediatric team.

Learning from complaints and concerns

- Staff told us that they did their best to deal with issues and complaints at a ward level. In the first instance the ward manager would speak to the patient and their family. This was true in the neonatal unit and the paediatric areas. We spoke to four families who had raised an issue with ward staff and all told us their concern had been resolved quickly.
- A Patient Advice and Liaison Service (PALS) team was available to patients and carers. Most parents we spoke with knew where to find the PALS office and what the role of its staff was. PALS staff pro-actively contacted wards when issues were raised with them. Staff reported that they received as many compliments from parents about the care at ELCH as they had complaints.There were very few formal complaints made. Complaints in relation to children's services were overseen by the Director of Nursing for the Evelina. The head of safeguarding nursing monitored any complaints related to the safeguarding of children. Themes of complaints were waiting times for appointments and the availability of accommodation as so many parents of inpatients lived outside London. More accommodation was being built.
- An example of learning from patient feedback was that parents on the neonatal unit had complained about having to leave their baby's cot during ward rounds. The solution had been to offer parents sound-excluding headphones to preserve patient confidentiality during the ward round.
- A free, confidential mediation service had been set up to help parents and clinicians recognise and manage painful and difficult medical and ethical dilemmas and help resolve decisions about treatment. This was especially useful when there were cultural misunderstandings. Staff considered the training they had had in managing difficult discussions had increased their confidence.

Are services for children and young people well-led?

Outstanding ☆

We found leadership in ELCH to be outstanding.

The vision to establish ELCH as a comprehensive specialist children's hospital within a regional clinical network was well understood and supported by staff. Staff were passionate about delivering high levels of care to the children and young people they cared for, and to their families.

The hospital had a clear clinical governance structure, focused on reducing clinical risk, monitoring quality and improving patient outcomes. Leadership was evident at local, service and hospital levels, and the channels for escalating risk, disseminating information and monitoring standards were clear. The trust was work closely with Lambeth CCG, the coordinating commissioner, on its capacity challenges, We found an open and transparent culture with motivated and compassionate staff who were well informed about the hospital's priorities as well as those of the wider trust, and felt they had a genuine role in shaping the development of the hospital. Staff told us they

valued the democratic culture. There was an ethos of continuous improvement. Families and patients also felt involved in developing the hospital through consultation and effective communications.

Vision and strategy for this service

- The vision was to establish ELCH as a comprehensive specialist children's hospital within a regional network and with some national services. The hospital would focus on improving the lives of babies, children and young people and their families, by providing consistently outstanding life-enhancing healthcare, educating and training people to deliver effective child-centred care and treatment and developing research activity to improve child health and change practice.
- Staff identified with the values of putting patients first, taking pride in what they do, respecting others, striving to be the best and acting with integrity.
- In 2012 the Trust had identified Children's Services as one of the four key priority clinical service areas for improvement and expansion. It was a medium income generator for the trust. The expansion planned for 2015/16 was to increase accommodation for parents, expand the intensive care and high dependency care facilities of the neonatal unit, open a children's long term ventilation unit following demand for the service, open a procedure room to reduce pressure on theatres and open a children's short stay unit for emergency patients. In the longer term there were major building developments planned.
- Part of the vision was to integrate with community services to create a local child health service and respond to the changing landscape of primary care and the children and young people's partnership health programme with clinical commissioning groups, mental health services, local authorities and a partner trust.
- Strategic review meetings were held every six months.

Governance, risk management and quality measurement

- Following a management restructure in April 2015, a team of six people led children's services. The Director had overall leadership of ELCH, with management responsibility for the hospital and the community services and the Evelina development strategy. The other key team members were the medical director, director of nursing, head of strategy, head of finance and a business manager. ELCH had a degree of autonomy in decision making. The Director of Evelina attended the Board of the Trust and one of the non-executive directors was the former Department of Health National Clinical Director for Children, Young People and Maternity. Senior managers were confident that the voice of children's services were heard at Board level.
- There were three directorates: Surgery and PICU, Medicine and Neonates (which included outpatients and therapies), and Community. Each directorate had a clinical director, a general manager and a head of nursing. Currently one head of nursing covered both the inpatient directorates. There was a governance lead in each service.
- ELCH encompassed all of the trust's children's services except allergy, anaesthesia / pain, dental surgery, dermatology, the children's emergency department, haemophilia, neurophysiology and ophthalmology. Children's imaging and theatres were also managed by adult directorates. The Trust Children's Services Committee, chaired by a non-executive director, had a governance role across all Children's Services. In this it was supported by the trust-wide Medical Director and the Director of Nursing for the Evelina. The children's services within other directorates of the Trust shared the Evelina identity even though their reporting lines were slightly different.
- The Clinical Governance Committee, chaired by the Medical Director, reported to both the Children's Services Committee and the Trust Risk and Quality Committee. There was feedback from these meetings to staff on wards.
- Gastroenterology and neurosurgery were provided jointly with another London trust and the arrangements were reported to work effectively.
- The ELCH Risk Register was reviewed monthly at the clinical governance forum and we saw evidence that new risks were added and old risks closed. Staff were proactive in managing risks. For example, they were closely monitoring mitigating action to improve delay in recognising a deteriorating child, for which new-style PEWS charts had been introduced. Other key risks were the lack of capacity for both inpatients and outpatients,

already in part mitigated by future building plans, and the need to extend coverage of the palliative care service. The register showed that risks were being identified and action taken to reduce those risks. The register was regularly updated with a brief description of action taken and action planned, and new risks were effectively communicated to staff. Incident reporting fed into the risk register where appropriate. Risks were also assessed in speciality areas, such as the monthly PICU or South Thames Retrieval Service forums. Information on risk management was well disseminated through local newsletters, for example the anaesthetic clinical governance newsletter.

- Directorates held monthly business and speciality meetings within a coherent reporting structure. Operational management meetings were held at matron level and ward level. The wards had regular team meetings at which performance issues, concerns and complaints were discussed. We saw minutes of ward meetings so staff who could not attend were nonetheless informed.Decision making to improve service quality was data driven.

Leadership of service

- ELCH had a new management structure. Clinical and non-clinical staff were aware of the leadership and management structure. Coaching had been arranged for senior leaders. Staff told us that they regularly saw directorate managers and clinical leads.
- We saw effective local leadership, with responsibility delegated to service level where possible. Ward staff felt well supported by their ward sisters and matrons, and told us they could raise concerns with senior staff as needed. Democracy was seen in action at all levels and many staff commented on the responsiveness of the leadership throughout the hospital. Staff felt their views were listened to.
- Managers were aware of the area where the hospital had challenges, the need for more isolation rooms, and managing growing demand for specialist care. There were plans to increase capacity in 2015/16 but if demand continued to grow at the same rate it could impact on capacity and consequently on performance.The hospital were working with Lambeth, the coordinating commissioner, on a fuller capacity review. Commissioners told us that Evelina Children's hospital was a proactive partner working collaboratively with stakeholders.
- Junior and middle grade doctors said they felt well supported by their consultants and other senior colleagues. Rotas had been changed after concerns about workload in the previous year. Consultants felt supported by the medical leadership in the hospital and the trust.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and giving clear direction and support to junior colleagues.
- The trust's Chief Nurse was evident in her trust wide leadership She led the 'Safe in our hands' meetings for the whole Trust. These were open to staff and also videoed so the messages could be viewed later by staff who were unable to attend.

Culture within the service

- Staff were passionate about providing empathetic and holistic,family centred care. They demonstrated evident pride in working in a hospital which they considered a centre of excellence.
- There was a strong team spirit from top to bottom. The atmosphere was friendly and purposeful. Staff as diverse as consultants, cleaners, radiographers and nurses worked supportively to meet the needs of children and young people. Staff had a 'can do' attitude and felt empowered to sort out any problems that interfered with good patient care.
- Managers had made a pledge to staff to involve them in decisions made about how the hospital's services were planned and delivered, to develop leaders among staff and to recruit and retain high quality staff. Staff were involved and engaged through local meetings, ELCH wide discussion forums, a quarterly heads of service forum, a senior leaders forum, a monthly Evelina forum, a junior doctors monthly breakfast meeting as well as by email communication. staff we spoke with felt comfortable raising issues or suggesting changes.
- We saw evidence of arrangements for developing the skills of staff with effective support, including coaching, mentoring and training opportunities.
- Staff demonstrated a strong commitment to equality and diversity

Services for children and young people

Child, family and staff engagement

- We observed that clinical and non-clinical staff were skilled in engaging with children, young people and their families by listening to their views and concerns and involving them in the development and delivery of the service.
- Feedback from parents was obtained from the NHS Friends and Family test, through comments received through PALS and through various ELCH specific patient surveys such as the 'patient experience washing line tool' and the 'tell us' monthly walk around sessions to gain information from patients and families.
- The views of young people were also gathered, for example through a group known as 'Evelina Pride', young people with complex needs who were frequently in the hospital. This group was supported by the paediatric psychology team to report what they liked and what they would like to change in relation to services, including proposed new projects or developments..
- The minutes of the clinical governance meetings showed that patient experience data was reviewed and monitored, and action had been taken where possible. Results and actions had been communicated across children's services on 'you said - we did' boards, in bulletins and on Facebook pages. A quarterly report was produced by the Head of Nursing for children services. A booklet had been produced for young people needing pacemakers as adolescents had felt the adult booklet was "aimed at old people".
- In a 2014 NHS Inpatient Survey, parents rated ELCH as significantly better than the national average in four key areas, namely, parents feeling involved in their child's care, staff agreeing a plan of care for their child with parents, staff keeping parents informed of what was happening to their child, and staff asking parents if they had any questions. However, children and young people aged 8-15 rated ELCH as worse than the national average in one area: they felt they were not given enough privacy when receiving care and treatment. The hospital's own internal feedback systems recognised that young people and their families would benefit from more quiet space and private facilities, particularly those in the hospital for longer stays. One issue was same sex accommodation in PICU. Currently patient notes recorded whether single sex accommodation had been considered, but dependency, staff levels and skill mix were also relevant and might override the desirability of single sex accommodation.
- The Department of Health's 15 Steps Challenge tool (a tool developed from a parent saying "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward") had been further developed by staff into the 'Evelina Detective', which focused on the quality of the clinical environment. We saw evidence of changes arising from this such as keeping bays tidy by providing storage boxes at the end of the bed and re-organising stock rooms. Patient experience information was displayed in all clinical areas. User groups were consulted when any specific service development was underway, for example, the ECHO cardiac user group was consulted as part of the Paediatric Congenital Cardiac services review.
- Staff felt engaged with the hospital's future strategy and the fair employer principles of flexible rewards and satisfaction.
- The hospital was on track for re-accreditation with the Investors in People Gold Standard and the Health and Well Being Good Practice Award. Managers at all levels were seen as approachable and there was a culture and ethos of supporting staff to progress.
- Sickness among the 1100 working time equivalent staff was consistently below 3%. Staff turnover was 8%.
- The quarterly staff friends and family test had been promoted through a newsletter. 94% would recommend the care, higher than the national average of 79% and higher than the trust average of 91%. Further, 85% would recommend ELCH as a place to work compared to the national average of 63% and the trust average of 77%. Pulse surveys had been carried out to gauge staff attitudes and concerns. Actions taken last year included introducing a monthly ward walk around to pick up equipment issues and identifying the need for a coordinator for children with complex needs. Staff views were also measured in an annual staff survey.
- There was a culture of celebrating achievements. An employee was designated 'Star of the Month', based on nominations by parents or staff, and could be anyone, including bank staff. 'Going the Extra Mile' awards were made for staff giving exceptional help. Staff were also awarded 'Certificates of Compassionate Practice'. There were external awards too such as by the Kings Health partners or the Nursing Times.

- Message of appreciation and thanks for staff from families came through PALS, through Facebook and Twitter as well as in writing. All thanks were publicised to staff.
- Staff contributed to the standards for the London Children and Young People's Strategic Clinical Network.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members. Staff said that new ideas and analysis of the way things were being done was positively encouraged by managers.
- 'Safety huddles' took place. During these huddles, staff worked together to identify critical safety issues in fast time and implement rapid solutions. Staff told us they believed this created a safer environment for higher risk patients.
- The paediatric cardiology service had introduced a home monitoring programme for infants following single ventricle palliation surgery (Norwood 1 operation or hybrid procedure). This allowed these patients to safely live at home with their families while they recovered and prepared for the second stage of their treatment.
- The South Thames Retrieval Service (STRS) led to the development of the national emergency air transfer service. STRS partnered with Airmed. All the retrieval team had undergone air retrieval training to prepare for helicopter retrieval of children in emergencies.
- An interactive outcome measuring tool for young children had been developed using a tablet computer. This would enable 5-10 year olds to comment on their experience as patients in a similar way to older children and young people, and parents. This was one of several novel approaches to seeking the views of patients and families.
- The pharmacy services at ELCH had made excellent research-based contributions to patient care and developed masterclasses and internships in paediatric pharmacy, as well as co-producing the Paediatric Formulary.

End of life care

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

Information about the service

Guys and St Thomas' NHS Trust has a specialist palliative care team (SPCT) within the oncology, haematology and cellular pathology directorate, which provides services to Guys 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 and the chaplaincy team provided multi-faith support.

The core SPCT offer a Monday to Friday 9 to 5pm service and offer 24/7 on call home visiting service. This is 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 calls service remained unchanged during this. During the inspection, we visited a variety of wards at St Thomas' Hospital, including: William Gull, Northumberland, Henry, Hillyer, Ann, Mark, Albert, ITU and the Emergency Department. 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 18 patients receiving end of life care. We observed the care provided by medical and nursing staff on the wards, spoke with three patients receiving end of life care and two family members of patients 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

Staff who worked in the specialist palliative care team (SPCT) demonstrated a multidisciplinary approach to caring for their patients.

They worked cohesively with generalist nurses and medical staff, respecting each other's skills, experience and competencies in a professional manner that benefited the patients they cared for.

The SPC was effective and provided 24/7 on call, in addition to the consultant out of hours cover. There was a temporary suspension of SPC nursing 24/7 service in June for a 4 month period which resulted in home visits being restricted to 9pm and telephone support to 11pm. The Consultant on call service remained unchanged during this period.

There was good leadership of the SPCT, with staff commenting senior managers were visible, approachable and willing to help out. They also provided consistent and prompt guidance and support. 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. We saw 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 for end of life care. This was in its infancy and staff commented it needed to be revised and made more achievable. Nevertheless staff spoke very positively of the multi-disciplinary team approach; the importance of quality outcomes for patients and the focus on providing care that was based on individual need. We saw, for example, that staff had arranged for the painting materials belonging to one patient nearing the end of life to be brought to the ward so they could continue with their art. 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 referred to the National Institute for Health and Care Excellence (NICE) quality standards for end of life care.

Bereavement support was available from the SPCT social workers, chaplaincy and the bereavement office. We saw patients were cared for with dignity and respect. Medicines were provided in line with guidelines for end of life care. Staff facilitated the rapid discharge of patients to their preferred place of death. 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 that there was no consistency in the recording of mental capacity assessments. We were told that there were sometimes delays in relatives being issued with a death certificate due to the unavailability of doctors to complete the paperwork.

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

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. Risk assessments were person-centred, proportionate and reviewed daily. Staff recognised and responded appropriately to changes in risks to patients receiving end of life care (EOLC). There was a specialist palliative care team which provided support and guidance to generalist nursing staff and medical teams. We saw a member of the SPCT meticulously check multi-disciplinary assessment following a referral from one of the wards.

We saw staff responded promptly to incidents, there was a culture of reporting, and a willingness to learn from errors so as to reduce the risk of them re-occurring. A department risk register was maintained, which listed identified risks and illustrated the action take to address them.

There was a fixed set of anticipatory medicines and we observed that staff paid particular attention to addressing symptoms of pain in their patients.

End of life care training was not mandatory for all staff however, the hospital had a number of different training courses in end of life and palliative care, and a training plan was in place which identified which grades of staff should attend the various courses being offered. Staff were positive about the level of end of life training available. 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 Cardio-Pulmonary Resuscitation (DNACPR) forms were stored in a number of places and staff could not always find them. There was also some confusion amongst staff as to the validity of a hospital completed DNACPR form if a patient was in transit or in the community following discharge.

Incidents

- No never events (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) 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 St Thomas' for the period 1 February 2015 – 31 May 2015. This indicated there had been nine hospital based incidents, of which two 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 that took place as a result.
- The trust maintained a record of opioid incidents. We reviewed those between February and May 2015. There had been eight incidents in total at St Thomas', relating to omitted medicines; a delay in providing medicines to patients and the wrong dose being given. No harm was recorded in six cases, and 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.
- The risk register for the oncology and haematology department, which maintained a trust wide overview of end of life care, listed four incidents specific to the mortuary. All were classed as an AMBER risk. One related to the release of the wrong deceased patient. We were shown by mortuary staff the systems they had subsequently introduced to prevent similar incidents happening in the future.
- We saw that staff reported incidents, they were investigated and learning taken from them. For example during our inspection we saw an incident involving a syringe driver. We saw staff respond quickly to address the situation, and also to take learning from it, which in this instance was to ask the doctors to prescribe the day before the medicine in the syringe was due to run out.
- Staff were positive about the 'without blame' approach within the Trust and said the culture was to report all incidents and lean from them.

End of life care

Duty of Candour

- Senior nursing staff and doctors we talked to 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. Junior staff were not aware of the changes.

Medicines

- Prescribing was solely the remit of the doctors as none of the specialist nurses were prescribers, although we were told this was something under consideration, and was something that the nurses were keen to pursue..
- There was a fixed set of anticipatory medicines on the electronic system with guidance for usage. Doctors told us it made prescribing the appropriate medicines much easier.
- Medicine administration records were completed accurately in the records we reviewed.

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 which was flagged to the SPCT so they could ensure patients received appropriate care.
- We reviewed the records of 18 patients, both electronic and paper where these were still being used. Generally the records were well maintained, with the exception of DNACPR forms. 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 in. This had been picked up by the SPCT who were in the process of developing guidelines for ward staff to address this. Senior managers told us they had recently conducted an audit to review this issue. They had also appointed a lead doctor to review how well the DNACPR forms were being completed in practice.
- We found that there was some confusion as to whether a DNACPR form completed on a ward would be valid for a patient being transferred to a community setting, be that their own home or an alternative abode. Senior managers confirmed that a form completed in the hospital would be valid for the ambulance crew carrying out the transfer and for the new place of residence until a new form could be completed by the primary care team. They accepted that this could be made clearer to staff.
- Staff were provided with a proforma which they could use to risk assess if a patient was in need of closer observation. This included scope for a mental capacity assessment.
- We saw SPCT staff complete a multi-disciplinary assessment post a referral from one of the wards. Staff checked that a number of steps had been taken, such as a discussion about preferred place of death and DNACPR; a medication review and whether the patient had been offered psychological and spiritual support. If any steps had not been taken, or had not been documented fully by ward staff, the SPCT nurse chased this up.

Safeguarding

- Staff told us they were provided with safeguarding information including who to contact with concerns.
- Those we spoke with knew the process to follow if they wanted to report any issues.

Mandatory training

- End of life care training was not mandatory across 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 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 whilst it was recommended that consultants and matrons completed training in the AMBER care bundle. All other end of life and palliative care training was optional.
- Junior doctors told us that in addition to the induction video, they had received training in the AMBER care bundle and the priorities of care. They also attended Schwartz rounds.

Assessing and responding to patient risk

End of life care

- Staff told us that for patients who were recognised as in the last few days of life an end of life notification was completed. This was flagged up to the SPCT who would determine their level of involvement, if any, based on each patient's individual needs.
- We saw staff had a specific multi-disciplinary risk assessment tool which was completed by the SPCT for each referral made to them.
- The trust used the early warning score system (EWS) to monitor acutely ill patients and alert staff of a deterioration in the patient's condition.
- 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

- Not all staff we spoke with were familiar with syringe drivers or how to use them. The SPCT told us that if there was a problem or incident with a driver on a ward they would be part of the team investigating the issue and would use this as an opportunity to provide general staff with further training, so as to reduce the likelihood of problems reoccurring.
- We saw that 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 were provided with appropriate personal protective equipment (PPE). We saw sufficient supplies of gloves, aprons and appropriate footwear. Changing rooms for staff included showering facilities.

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 team was managed by a matron, who in turn was supported by a head of nursing.
- The team was supported by two palliative care social workers.
- Staff rotated across both hospital sites and the community team to give a breadth of experience.
- There was a vacancy within the bereavement office team. Staff commented that at times this made it difficult to run the service at the level they wished, particularly if there was only one staff on duty. It meant that, for example, relatives had to wait to be assisted.

Medical staffing

- The SPCT had the equivalent of four WTE consultant posts – 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.
- The specialist registrar told us that full ward rounds were completed at weekends at both hospital sites so as to ensure the SPCT was fully informed of any problems arising or new patients admitted.

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.
- 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

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.

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

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 had performed well in the 2014 national care of the dying audit, exceeding the national averages in the majority of key performance indicators.

The hospital did not uniformly use pain score charts. Some wards used them while others did not. We saw this could lead to a delay in a patient receiving appropriate and adequate pain relief.

Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff; and used to improve patients care and treatment. A wide range of information was available for staff on the intranet however not all staff were aware of this.

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 had initially been suspended but was now operating reduced hours.

Generalist staff spoke highly of the SPCT and valued their input. A number of wards had an end of life link nurse and they were given allocated time to keep their skills updated. We were told by some members of the SPCT that they had not undertaken physical examination skills training which limited their effectiveness. Some generalist staff commented on the need for training in using syringe drivers.

The on-going change to electronic patient records had led to some confusion with staff, on occasion, struggling to locate information relevant to their patients. Mortuary staff had also been provided with a new IT system but commented that it was not yet fit for purpose and had a number of redundant functions.

We noted that in several cases staff had not completed a mental capacity assessment on a patient when it appeared appropriate to do so.

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.
- Staff could access bereavement guidelines through the hospital intranet. Not all staff were aware of the information available on the intranet or knew how to access it.
- 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. We saw that notifications were regularly audited to ensure any issues were identified and learning taken from it.
- We saw that staff were using the AMBER care bundle, which was designed and developed at this hospital (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).
- The Sage and Thyme model was part of mandatory training for junior doctors in oncology (the model is designed to train all grades of staff how to listen and respond to patients/clients or carers who are distressed or concerned).
- Care plans for end of life patients were based on the Five Priorities of 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 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 was 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.

End of life care

- We saw evidence of good individualised care including anticipatory medicine, fast track discharge plans and discussion with relatives.

Pain relief

- The hospital did not uniformly use pain assessment score charts. The palliative care team used the Abbey 1 – 10 score chart, but senior managers were unaware why this was not used across the hospital. The electronic patient record system automatically generated a pain assessment tool but we saw that this was inconsistently used and recording of discussions with patients regarding their level of pain was sometimes minimal. In seven out of the 18 patient records we reviewed there was no information to guide staff on how to assess the patient's pain.
- We saw staff considered adequate pain relief for end of life care patients to be a priority and where needed staff sought guidance and input from the SPCT. However, due to the lack of consistent pain measurement tool, there could be a delay in a patient receiving appropriate and adequate pain relief.
- 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. The nurses we talked with were clear about the medicines used for pain relief.
- We observed where analgesia had been changed following input from one of the SPCT.
- Patients told us that they had received prompt pain relief and their pain was dealt with effectively.

Nutrition and hydration

- The trust 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 being used to indicate patients who needed additional help at mealtimes. Mealtimes were protected and we saw staff of all grades stop what they were doing to give help to patients who needed it. Where red trays were used, these patients were served last so that their food did not get cold whilst waiting for staff to assist them.
- We saw that end of life patients were kept hydrated, orally, intravenously or subcutaneously, albeit not all junior nurses were aware that end of life patients were kept hydrated. Patients fluid and nutritional needs were documented in their individual care plans.

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 visited and team members provided support to both patient and ward staff. Approximately 40% of all end of life patients were referred to and seen by the specialist team.
- Staff in the critical care unit told us the chaplains called every day to see if any patient was having treatment de-escalated, in which case they would visit.
- We observed staff on the wards using an early warning system to monitor patients who were recognised as in the last few days of life. The patient was regularly reviewed 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 planned in line with the five priorities of care for the dying patient. Staff were also using the AMBER care bundle.
- Palliative care staff were able to access and contribute 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.
- We observed great care and attention being given to patients who had died; and to their relatives who visited them in the mortuary.
- The trust participated in the 2014 national care of the dying audit. It 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, for example, prescribing pre-emptive medication (17% compared to 50%) and for some of the key performance indicator regarding

privacy, dignity and respect protocols. We saw the Trust had prioritised the action 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 trying to fill its specialist nurse vacancies. A number of measures were in place to address this including developing the skills of existing staff using a comprehensive competency package.
- 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 trainees told us they were more than happy with the quality of the training and the level of support they received.
- 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 talked to did not raise any issues. They told us they were asked at interview if they were able to work with the deceased, were provided with training, and they were able to access counselling if needed.
- Most of the 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. They spoke highly of the SPCT and valued their input. They felt that individualised nursing care was enhanced if an end of life notification was made, as it encouraged communication and discussion around best practice.
- Most, but not all of the nurses we spoke with had attended, or were booked to attend, end of life care training and had received an update on the priorities of care.
- A number of wards had an end of life care link nurse. They were allocated one day per month to update their knowledge.
- Senior staff were able to clearly articulate what the AMBER care 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.
- SPCT staff met regularly for clinical supervision with a psychologist.
- Some staff on the wards told us they had not had training in using syringe drivers and did not feel competent to use them.
- 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.
- 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.
- We were told by some SPCT staff that they had not undertaken physical examination skills training which limited their effectiveness.

Multidisciplinary working

- The SPCT included social workers and a dedicated pharmacist who provided a multi-disciplinary input into end of life care.
- We observed excellent communication between the SPCT, patients and nursing and medical staff.
- 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.

End of life care

- Generalist staff told us they could refer to the specialist palliative care team without the need for a referral from the medical team, and they welcomed this autonomy.
- The trust was in the process of changing to an electronic patient record system. This meant that at the time of this inspection staff were working between paper and electronic records; and also, because the SPCT worked with two other electronic software programmes, between three different systems. This led to some inconsistencies in recording, with staff not always able to immediately find information.
- We saw clear lines of communication and joint working between the mortuary staff, staff in the bereavement centre and the SPCT.
- 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

- The trust had to temporarily reduce its out of hours in June of this year. Specialist nurses were available for consultation until 2300 and provided community visits until 9pm. The Consultant on call service remained unchanged during this period. This arrangement was being regularly monitored with no confirmed adverse patient outcomes to date albeit the team was reviewing if some patients had waited at home longer than was ideal because they did not want to contact the team unless staff were available.
- The use of the on-call team was reviewed every quarter so as 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' service to provide a rapid response to patients who had been discharged.
- The SPC Consultant on call service remained unchanged and continued during this period.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 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. Staff felt this was particularly problematic in the emergency department as staff there could not access palliative care notes which sat in a different system. To address this SPCT staff were writing an additional summary to add to the electronic patient record but this was a time consuming solution.
- Mortuary staff told us they had the first part of a new IT system which, whilst an improvement on paper records, was still not ideal as it contained a number of redundant sections. They had been provided with tablets to ease access but we were told these did not function. The new system did not synchronise with the system used for post mortem recording, which in turn was different to the system used by the pathologists for their reporting. Staff said this was being reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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. We saw that senior nurses were aware of this, but not all junior staff, and not all doctors.
- For a number of patients where it may have been appropriate to carry out a mental capacity assessment, we found staff had not carried one out.
- Staff were provided with a specific mental capacity assessment tool. Use of this varied from ward to ward, and some staff commented they wanted more education regarding mental capacity and deprivation of liberty.
- Doctors told us they rarely had to complete a deprivation of liberty (DOLs) application, but if they did they would discuss all possible cases with the safeguarding team.

Are end of life care services caring?

End of life care

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.

End of life patients were supported, treated with dignity and respect, and were involved as partners in their care**.** 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.

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. They told us that they 'could not get any better hospital'; and that the palliative care team was 'on point and amazing'.

Patients were treated with kindness during all the interactions we observed. 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. Some wards operated a drop in clinic for relatives where they could meet with a consultant and the ward manager.

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 patients belongings. Mortuary staff offered hand and foot prints cast in clay for parents who had lost an infant.

We noted staff had put small whiteboards near to patient's beds so that anyone visiting the patient were informed of their name, what they preferred to be called, and what their needs were for that day.

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 we spoke with commented that they were very pleased with the care they received. They commented they had been treated with 'love' and 'compassion', and that staff went the 'extra mile'. Carers told us they were kept informed and had been prepared for what was to come.
- Family and Friend Test results were displayed on the wards, with charts to show what had been done well and what could be improved. The Trust's performance in the Friends and Family Test was consistently above the England average.
- Staff were complimentary about the availability of the chaplaincy service, and commented that they would always come to the ward when called to support a patient.
- The chaplain confirmed they would visit wards when requested to support patients and relatives.
- Staff shared with us a poem written by a patient at the end of their life and which they left under a pillow. It described the nurses as angels.
- We saw staff had arranged for one patient to have their painting equipment brought to the ward so they could continue with their art work.
- The bereavement office offered questionnaires to relatives or friends of those who had died. An analysis of those returned between July and September 2014 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 proper bag, decorated with an empathetic picture, for them to take home a deceased patients belongings.
- We saw staff in the mortuary offered hand and footprints cast in clay, where appropriate, to parents who had lost an infant.
- If a deceased patient had no known next of kin the hospital would arrange the funeral, and mortuary staff would attend.
- Staff in the critical care unit compiled memory boxes for families which contained, for example, locks of hair and hand prints.
- An annual remembrance ceremony was held in intensive care and in Southwark cathedral. The service was well attended

Understanding and involvement of patients and those close to them

End of life care

- Patients, and, where more appropriate, relatives, commented that they understood the plan of care and that staff had discussed it with them.
- We saw some wards operated a weekly drop in clinic for relatives where they could talk with a consultant and the ward manager.
- 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%).
- Where possible, a patient nearing their end of life was given a side room. Relatives were provided with a family care pack containing basic toiletries, snacks and something to drink. If possible and where relevant a car parking permit was also provided.
- 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.
- Staff in the emergency department told us that they would allow a relative to remain with a patient even if they were attempting resuscitation. In such cases a nurse would be allocated to stay with the relative to explain what was happening.
- If a patient died in the emergency department staff would send a condolence card to the family. The card had been designed by staff who had also sourced funding.
- Mortuary and bereavement office staff demonstrated they understood where religious needs required a prompt burial, and worked hard to facilitate this. They also described how they had found appropriate devices to replicate candles, for example, so these could be placed next to the deceased.

Emotional support

- We observed a ward round by the SPCT consultant. We saw staff spoke 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.
- We observed whiteboards beside patients beds which stated the allocated nurses name, the patient's name, what they were known as and what their needs were for that day. We saw this was effectively used for a patient with learning disabilities.
- 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%.

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 importance of flexibility, choice and continuity of care was reflected in the services provided at St Thomas'. For example staff facilitated the wishes of an end of life patient who wanted to have a cigarette.

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

We saw that patients 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 later needed.

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.

Staff were proactive, anticipated where additional resources may be required, and where necessary sourced funding to enable changes to be made.

We noted that not all staff were aware that interpreters could be arranged, and had struggled with a non-English speaking patient around whom there were safeguarding concerns.

Staff told us that there were often delays in issuing a death certificate as the appropriate doctor either could not be easily located or did not have the time to go to the bereavement office to complete the paperwork.

The mortuary provided satisfactory facilities for laying out deceased patients and enabling relatives to visit.

End of life care

Complaints, of which there were few, were dealt with promptly and staff were able to outline to us the lessons learned from a recent complaint.

Service planning and delivery to meet the needs of local people

- We saw the SPCT completed a discharge summary for each patient they saw who was going home, or to a hospice. This was stored in the electronic notes. Staff were trialling completing a similar summary for every patient on their caseload rather than just those being discharged.
- We saw that 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.
- Discussions were underway with the local registry office to establish if a service could be provided from 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.
- 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%.
- 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.
- 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.

Meeting people's individual needs

- Staff demonstrated they were focussed on meeting individual patient's needs. For example staff told us about an end of life patient who wished to smoke. Staff facilitated the patient being able to have a cigarette.
- 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.
- We saw the hospital had information on the chaplaincy services available during the day. There was always 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.
- Where possible relatives were provided with a bed so they could stay with their family member if they were approaching the end of their life.
- 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.
- We saw that the SPCT liaised with colleagues in the learning disability team to explore ways to better inform patients with a learning disability of their prognosis and to develop joint team training.
- For patients and relatives of patients affected by cancer, the Dimbleby Cancer Care charity provided a drop-in centre at the hospital. This was staffed by health professionals who would help patients and carers to find any information they need. Books, leaflets, audio- and videotapes and DVDs were available.
- The bereavement centre carried out the administration of a deceased patient's documents, including the certificate of death. Staff told us there were frequent delays in issuing the certificate due to the difficulty in finding the correct doctor and getting them to go to the centre to complete the paperwork. We saw this had been flagged to the deputy chief nurse who had asked bereavement office staff to escalate any delays to her.
- 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 although they would try to make exceptions for children.

End of life care

- We noted that not all staff were aware if interpreters were available. We saw one patient, where there were safeguarding concerns and who did not speak English, yet an interpreter had not been arranged.

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.
- 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 normal range.
- We found that the mortuary provided a satisfactory room for laying out deceased patients and sympathetic surroundings to help with visiting relatives. Staff assured us that no relatives would visit the mortuary unaccompanied. We observed that this was the case during our visit.
- Staff facilities at the mortuary were very cramped. Staff told us they were trying to find innovative ways to improve this.
- We were informed that the door between the relatives viewing room and the rest of the mortuary was not soundproofed which meant that at times, unavoidably, relatives would be disturbed by the work being carried on in the mortuary.
- The hospital had a bereavement centre which was tastefully furnished. Staff there did not offer counselling to support relatives but did provide them with information about such services.

Access and flow

- We saw that 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 trust target of 30%.
- Once alerted, staff tried to ensure fast track discharges took place within 24-48 hours.
- The palliative care scorecard indicted 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 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.
- Data provided by the portering service indicated that deceased patients were collected from the wards in a timely manner, often within 40 minutes.

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 from family members about their relatives treatment, 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 just one related to palliative care (paediatric neurology) at St Thomas'.

Are end of life care services well-led?

Good

We saw the department of palliative care operated in an embedded framework within which 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 clear statement of vision and values for end of life care, which staff were familiar with and promoted. One member of staff told us the values were what led them to apply to work at the Trust. 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.

End of life care

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

Staff told us they felt very well supported by senior management, in particular the deputy chief nurse, and found them to be approachable, informative, visible and helpful. Some staff expressed concern at the plan to recommence a 24/7 palliative care service and the impact this could have on their working hours.

All staff were positive and demonstrated a proactive attitude towards caring for dying people. They told us there was a culture of 'no blame' which encouraged them 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.

Vision and strategy for this service

- Staff told us that the hospital's values were embedded. One commented that they had chosen to take up a post there because the values were displayed by staff in all areas.
- 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 that this was largely an aspirational plan which would be difficult to put into practice in its entirety. 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 other staff.
- The End of Life (EOL) governance committee met monthly and had a number of working groups to carry forward EOL developments. For example a discussion was held about joint teaching between the EOL team and the learning disability team, 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. 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 team; actors had been introduced into the assessment process to carry out role plays to enable the assessors to better determine the assessment skills of the candidates; whilst nurses were being encouraged to take on roles at a higher grade so as to gain experience and confidence.
- The suspension of the out of hour's service after 11pm was being continually monitored and there were on going discussions with commissioners to explore viable options, including a possible triage service with a local hospice.
- The lead Consultant had a teleconference with the out of hours GP service to review cases and efficiencies of working.
- The oncology and haematology directorate, where the SPCT were located, maintained a risk register. Up to 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.

End of life care

- One risk rated as amber on the risk register related to ongoing problems, since July 2014, with the ventilation system in the post mortem room. We saw the hospital had now put out to tender for replacement of the entire ventilation system.

Leadership of service

- There was excellent leadership of the SPCT, led by the senior consultant and the chief nurses.
- All staff we talked with spoke highly of the deputy chief nurse (cancer) and the chief nurse. They described them as always available, helpful, approachable and willing to step in when short staffed. Staff were similarly positive about the approachability and guidance offered by the palliative and end of life lead clinician.
- 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.

Culture within the service

- We talked with a number of members of the SPCT. All were positive and demonstrated a proactive attitude towards caring for dying people. They were able to describe how their work impacted on the overall end of life service and how important it was.
- Staff were clearly passionate about supporting not just end of life patients but their family members as well.
- Staff commented that there was a culture of 'no blame'. Everyone was encouraged to learn from incidents and staff said they were always provided with feedback after any incident. As an example, four patients had recently developed an infection. A root cause analysis was carried out, all staff interviewed, and improved hand hygiene protocols were put int place. Staff commented that they had all learned from this.
- Staff spoke of feeling engaged and being enabled to regularly liaise with colleagues from different areas than their own.
- 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 the SPCT was integrated well with nursing staff and the clinical teams.

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 on the board.
- We saw 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

- Staff were encouraged to play an active part in the planning and development of the service. Regular meetings were held to review how the service operated; and to highlight any areas for potential improvement.
- 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 organised a fortnightly debriefing session to provide psychological support.
- Care was taken to ensure the safety of the out of hour's 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.
- Counselling for staff could be accessed at any time.
- Staff told us they were encouraged to develop their skills and experience.

Innovation, improvement and sustainability

End of life care

- 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 3 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 advance 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.
- Some staff expressed concern at the drive to re-establish a full 24/7 palliative care service as this had previously proved challenging for staff and they felt this was why some had left the hospital.
- Staff told us that they were enabled to undertake research projects and had close links with the hospital's academic department. A current research project was assessing a tool to measure outcomes in palliative care.
- We saw staff were keen to develop and share good practice. If guidelines were not available for a specific issue staff would draft their own and send it to senior staff for approval.

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 572,051 first and follow-up outpatients appointments booked at the hospital in 2014. Outpatient clinics included fracture clinic, physiotherapy, neurology, ophthalmology, dermatology, paediatrics, obstetrics, occupational therapy, genitourinary medicine, pain management, and cardiology, among others. Physiotherapy, dermatology and ophthalmology were among the most attended clinics in 2014/2015, followed by obstetrics, occupational therapy, plastic surgery, cardiology and fracture clinics. The imaging department included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, and x-ray areas. Individual outpatients clinics were coordinated by corresponding surgical or medical specialities and numerous divisions within these specialities, there was no outpatient department.

We visited the general outpatients, the dermatology clinic, oncology, ophthalmology, fracture clinic, radiology, women and children's outpatient clinics, cardiology department and pain management clinic. We spoke with 45 patients and some of their relatives or carers. In addition, we spoke with 85 members of staff, including managers, doctors, nurses, radiographers and radiologists, administrators, receptionists and members of the health records team. 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.

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. Only a minimal number of nursing and medical and dental staff had received dementia awareness training.

Patients told us they felt involved in their care and that they were treated with dignity and respect. they also felt involved in decisions about their care and treatment. Staff knew how to report incidents and raise a safeguarding alert, they were encouraged to report incidents and received direct feedback from their line managers. Staff told us they were able to share ideas and concerns openly. Complaints were handled in line with the trust policy and patients feedback was used to improve the service.

Equipment was tested and in date to ensure that it was safe. Emergency medicines and emergency equipment was in place and up-to-date. There was a sufficient number of nurses and medical and dental staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required. Patients' care was well organised, with individual patients being discussed during multidisciplinary team meetings. Staff were

Outpatients and diagnostic imaging

competent and had had appraisals within the past twelve months. They had access to information in order to support decision making and offer appropriate care and treatment.

The trust had met the national waiting time target of 18 weeks for non-admitted and incomplete pathways. The trust had also consistently performed in line with the England average in relation to the two week wait urgent referral performance target. The trust had systems which allowed gathering data, they were able to analyse it to identify risks and prioritise patients accordingly to clinical need.

There were long term strategies developed for individual departments and staff were aware of them. Staff felt that they could influence decisions made in relation to day to day running of their department and felt empowered by their management. There was a culture of openness and transparency.

Are outpatient and diagnostic imaging services safe?

Good

Staff knew how to raise a safeguarding alert and they were encouraged to report incidents and received direct feedback from their line managers. Equipment was tested and in date to ensure that it was safe. Controlled drugs were accounted for and managed as guided by the published guidance. Emergency medication and emergency equipment was in place on up-to-date resuscitation trolleys, and these were checked. There was a sufficient number of nurses and medical and dental staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required.

Incidents

- One incidents 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 patient with a grade 3 pressure ulcer which developed at home and was observed by the medical ophthalmology staff. Staff took appropriate actions in response to this incident.
- There were no never events (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.) related to delivering outpatient services at the hospital. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- 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 trust's incidents reporting system. These included four incidents categorised as low harm.
- 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, taking into account the contributory factors which may have contributed to the incident. The managers we spoke with confirmed that information relating to reported incidents was collated and discussed by the management at quality meetings, and minutes we saw confirmed it.

Cleanliness, infection control and hygiene

- Staff had infection prevention and control training as part of their mandatory training.
- Clinical areas and waiting rooms were mostly visibly clean throughout the outpatient department. There were hand cleansing facilities for patients and staff. We saw that staff used personal protective equipment such as gloves and aprons when appropriate.
- We observed that some floors within the outpatient clinics had carpets. These could not be cleaned easily. Staff we spoke to were unclear as to how often they were cleaned or the method used. We also noted there was carpet in the entrance and waiting areas in the MRI department. In other outpatients clinics we noted chairs with stained fabric cover were used in waiting areas. Staff told us these were cleaned recently but there was no record of the cleaning schedule or methods used.

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

Medicines

- Refrigerator temperatures were monitored and drugs were stored safely, all medicine cupboards we checked were locked. Keys to the locked medicine cupboards could only be accessed with a code by trained staff.
- All controlled drugs were accounted for and managed in line with published guidance.
- Staff told us they were trained in medicines management and were aware of their responsibility in the safe administration of medicines.
- All emergency medication and emergency equipment was in place on up-to-date resuscitation trolleys, and these were checked daily. In most of the clinics we visited, we noted that daily checks of the emergency medication and equipment had been undertaken. All the medicines we checked were in date.

Records

- The clinical records kept were a combination of electronic records and paper files. Paper records in 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.
- Nurses and doctors told us required information was readily accessible to them. However, the trust did not audit records availability in clinics.
- Patients' paper records were stored at the hospital and staff was able to communicate directly with the relevant department if they were trying to find a personal medical record. The medical record team aimed to dispatch records a minimum of one day in advance of the planned clinic. Nurses and doctors across all clinics told us that occasionally patient records were delivered late, or that they were only given a patient's temporary set of notes. Doctors told us that it was 'inconvenient' but they were still able to see patients, and that no appointments were cancelled as a result because they had access to the parallel electronic record system. Nurses and receptionists told us most of the missing notes could usually be found on the day of the appointment and it did not cause delays to patients' appointments.

Safeguarding

- 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 at the trust varied between 50% and 100%, with the

average at 83% in 2014/2015. The information provided by the trust indicated that none of the administrative and clerical staff working in clinical imaging and medical physics had completed adults safeguarding training and only 50% had completed safeguarding training related to children. The target set by the trust was 95%.

- The training compliance rate, among outpatients staff working at the hospital, for training related to safeguarding adults was 91%, this training included information related to Mental Capacity Act and Deprivation of Liberty Safeguards.
- 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.
- The safeguarding adults team comprised of safeguarding adults leads, clinical nurse specialists for dementia and delirium and learning disability, safeguarding and 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 training and 83% fire safety training and 82% other mandatory trainings.
- Staff working within the three largest outpatients directorates that deliver their services through outpatients at the hospital (GRIDA, Medical Specialties and Dental) had achieved 84% mandatory training compliance. Over 95% compliance was recorded for equality, diversity and human rights training, basic life support (children) and medicines management. Low rates were indicated for infection prevention (clinical staff; 67%) basic life support (adults; 74%) manual handling (83%) and information governance (69%).
- There was a low training compliance rate among administrative and clerical staff working within therapies, medical specialities and clinical imaging and medical physics department.
- Only 83% of nurses working within medical specialities department had completed basic life support training. We have not been provided with information on how many doctors and medical staff working at the hospital had completed this training.

Assessing and responding to patient risk

- Rapid access and walk in services were available across medical and surgical specialities. It included a clinic for patients who had suffered a stroke, a suspected transient ischaemic attack (TIA) or a mini-stroke. These patients were offered rapid assessment and treatment, with all necessary investigations performed on the day of the clinic. There was also a chronic obstructive pulmonary disease (COPD) clinic for patients referred internally and a daily tuberculosis and pleural effusion walk in clinic. These clinics helped to prevent delays to patients' treatment and minimise risk of deterioration. Many other services allowed patients to access care rapidly, for example at the HIV clinic where ad hoc appointments were available.
- 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 week target. Patients were referred directly to the two week wait office. There was a system for monitoring patients' referral to treatment times and identify those who had waited for a prolonged period of time, or whose appointments were cancelled multiple times. It was used effectively and staff were aware of how they performed in relation to waiting times. Diagnostic imaging services reported on diagnosis within a timely manner to avoid delays, with most reports being produced on the same day.
- There was emergency equipment available to respond in the event of emergency. The equipment was easily available and checked daily.

Nursing staffing

- The sickness rate for the outpatient departments was 3.4%. This was slightly higher than the hospital average of 3.2% (June 2014 to May 2014; including the dental

department, medical specialities, therapies, clinical imaging, genetics, rheumatology, infection, dermatology and allergy). The sickness levels among medical and dental staff were below 1%. Worse rates were noted among administrative and clerical staff (4%) and nursing staff (3.8%).

- The staff turnover rate for medical specialities, and genetics, rheumatology, infection, and dermatology and allergy department was 14.7% for 2014/2015. This was better than the hospital average (16.2%). The highest rate was recorded among administrative and clerical staff working in the genetics, rheumatology, infection, dermatology and allergy department (GRIDA) and dental services (29%).
- The turnover rate for nurses was 10% and for medical and dental staff was 8%. These were better than the hospital average.
- The average vacancy rate for the hospital was 15%. Records indicated that it was 16% for dental services, clinical imaging, medical specialities, and genetics, rheumatology, infection, and dermatology and allergy department, with a low, 7%, vacancy rate among nursing staff.
- Staff told us that use of agency staff in outpatient clinics was very occasional. The trust reported an average rate of 5% for GRIDA and medical specialities at the hospital (May 2015).
- Overall there was a sufficient number of staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required.

Medical staffing

- We observed that there was a sufficient number of doctors to run all scheduled outpatient clinics. The average vacancy rate for the hospital was 15%. Records indicated that it was 16% for dental services, clinical imaging, medical specialities, and genetics, rheumatology, infection, and dermatology and allergy department, with a low, 1.5%, vacancy rate medical and dental staff.

Major incident awareness and training

- 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 informed local managers and staff 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

We saw good examples of multidisciplinary working and staff told us they were able to share ideas and concerns openly. Patients' care was well organised, with individual patients being discussed during multidisciplinary team meetings. Staff were competent and clear on what their role was, most of the staff had been appraised with the past twelve months. Clinical staff had access to information in order to support decision making and offer appropriate care and treatment.

Evidence-based care and treatment

- We were told that guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines were followed where appropriate. Staff told us they worked in line with NICE guidance and local policies. Best practice guidance was followed in the ophthalmology department when treating medical eye condition.
- The outpatients' matron received NICE and Medicines and Healthcare products Regulatory Agency (MHRA) alerts and then cascaded this information to their nursing staff. There was an information notice board at each clinic and in the staff room for use by all staff.
- Staff were aware of how to access policies and procedures online. Nursing staff told us how new practice guidance could also be cascaded through the specialist area they were working in. This was done through teaching and training sessions organised by the clinical nurse specialists or the nurse consultants.
- 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 2000 (IRMER) 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.

- There were clear standard operating procedures for diagnostic x-ray and nuclear medicine as required by IRMER. These addressed patient identification and responsibilities of individual members of staff, and also set training requirements.
- 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 type2 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.
- 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.

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. 75% 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.
- Patients had access to the pain management and neuromodulation centre which supported them in chronic pain management via the outpatient pain management department. This clinic specialised in spinal cord stimulation and management of psychological, physical and social impacts of chronic pain.

Patient outcomes

- The trust is the only trust in the country to provide a medical eye clinic. Referrals were received for the medical eye clinic from all over the country, and patients' treatment protocols were spread over 3 days, with accommodation provided for patients who were undergoing the medical eye treatment program.
- The follow-up to new appointments ratio for the hospital varied between 2.1 and 2.3 in 2014. This was slightly below the England average (2.3). We were unable to analyse how these corresponded to individual specialties due to lack of data.
- 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 an additional 12% partially staged. The upper gastrointestinal (upper GI) department had seen a near 20% improvement on the number of staged cased. 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 surgeries to take place. Lung cancer audit results 2014 that 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. However, the survey also 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 a name of a 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

- Staff were able to explain to us what their role was and told us they were provided with training, development and supervision to ensure they were able to do their job effectively. 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 the clinical staff told us that she was provided with an opportunity to undertake professional study at the university.
- Records provided by the trust showed that 66% of all staff working within clinical imaging, medical specialities and GRIDA 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 saw evidence of positive multidisciplinary (MDT) working in a variety of clinics. For example in the chest clinic, nurses ran clinics that could incorporate input from physiotherapy, psychology and occupational therapy. Nursing staff and healthcare assistants we spoke with in other clinics, such as dermatology and renal, told us the teamwork and multidisciplinary working was effective and professional.
- A range of clinical and non-clinical staff worked within the outpatients department and told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines including radiographers, physiotherapists, nurses, booking staff, and consultants. Staff were seen to be working towards common goals. They asked questions and supported each other to provide the best care and experience for the patient.
- 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 surgeries to take place as a result of an emergency. Lung cancer audit results 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 routinely available Monday to Friday, 9am to 5pm, to patients referred by General Practitioners and doctors working in outpatients departments. Clinical imaging services that aimed to provide services for inpatients and in emergency were available seven days a week.

Access to information

- 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 was 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. Electronic patient records were available in hospital clinics and community clinics. We were told that no procedures were performed in all procedure based clinics such as dental, or ophthalmology if appropriate notes were not available.
- Appointment letters were sent to patients on day of the appointment booking or the next working day for all services with an average of 2 days. The trust did not monitor how long time it took to report on diagnosis or outcomes of the treatment to patient's local GP. Nurses and doctors told us communication with GPs was effective and that letters were sent promptly within the maximum of 5 days. There were no backlogs or delays. Allocated patient's coordinators were able to communicate with patient's GP when required.

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 outpatient department.

- Nurses and some of the doctors we spoke with were unclear of procedures they would follow should a patient's capacity to consent be in question. Staff were unable to describe procedures such as mental capacity assessment or the procedure for reaching a decision.

Are outpatient and diagnostic imaging services caring?

Good

Patients told us they felt involved in their care and that they were treated with dignity and respect by all staff. Patients felt involved in decisions about their care and treatment, and were given written information regarding potential side effects of their treatment. Chaperones were provided whenever needed. Clinics provided patients with additional information and encourage to be involved in their care by running educational workshops.

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 them of the waiting time.
- Patient consultations took place in private rooms.
- 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 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 children's outpatient services and therapies were among those mostly recommended with between 95% and 98% positive responses received in July 2015. Slightly lower scores were reported for clinical imaging and women's services (89%) and medical specialities and GRIDA services (90%).
- Chaperones were provided whenever needed. No specific chaperone training had been given to them. There was a chaperone policy which took into consideration management of chaperoning in sexual health, gynaecology and safeguarding the welfare of children. 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.
- 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 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 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 involved in their care. They said that 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. This 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

Outpatients and diagnostic imaging

- In 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.
- 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

The trust performed worse than the England average in every month since April 2013 in relation to the 62 day standard for 85% of cancer patients to wait less than 62 days from urgent GP referral to first definitive treatment. Only a minimal number of nursing and medical and dental staff had received dementia awareness training.

We also noted that complaints were handled in line with the trust policy. The trust had mostly met the national waiting time target of 18 weeks for non-admitted and incomplete pathways. The trust had also consistently performed in line with the England average in relation to the two week wait urgent referral performance target. The hospital was able to prioritise patients whose appointment had been cancelled on more than one occasion to avoid delays.

Service planning and delivery to meet the needs of local people

- 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, except 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 trust had developed a 'way finding strategy' which 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.

Access and flow

- In the main outpatient department building, Gassiott House, there were electronic checking-in stations for outpatients. Patients were required to check themselves in and then proceed to a main waiting area for a group of clinics. The check-in machines could also be used by patients to update their basic details such as address or phone numbers. At the main waiting area, a screen displayed the names of patients to be seen and the room they need to go. The also displayed waiting times when clinics were running over 30 minutes late.
- The level of 'did not attend' at the hospital (varying between 13% and 15%) and across 2014 was slightly better than 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 judge suitability. 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 ran their own nurse-led clinics. 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.
- 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 that the average time to send a letter was 2.2 days, with the quickest turnaround times 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).
- We were told by management of the appointments and booking office that the service was at risk due to a shortage of staff and an increase in workload. There was poor coordination of appointments with patients' appointments frequently being rescheduled or cancelled in order to meet the demand of the service and ensure patients at risk were seen first. Staff told us that the rescheduling of cancelled appointments and clinics remained a consistent problem for the service. The service recruited additional 2.5 WTE (whole-time equivalent) staff to deal with the issues but at the time of the inspection it was too early to notice improvement. In the ophthalmology clinic (corneal clinic) there was a backlog of 400 appointments waiting to be scheduled.
- On average, 7.5% of outpatient clinics' appointments were cancelled by the hospital (February to May 2015). The trust informed us that 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 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 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 the 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 types of suspected cancer). We noted that the trust achieved 93% in April to June 2015 which was also similar to the England average. Suspected children's cancer (62%), 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 scale. Although data analysed by us confirmed it, 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 specialities. 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).
- 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

- We observed that the volunteers worked very proactively, being helpful and respectful towards patients. Several patients we spoke with commented on the help and support that was provided. The volunteers were always ready and willing to assist patients and visitors to the hospital.
- 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. There was an interpretation service available through the language line; however we had not seen any patient information leaflets in different languages other than English. The census in 2011 highlighted that 3.4% of the borough's population spoke Portuguese as their native language, another 2.5% spoke Spanish, 2.2% spoke Polish and 1.8% spoke French. Only 80% of the borough's population spoke English as their native language.
- Easy to 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. Patients could access all available leaflets related to various medical conditions online by accessing the trust's website

- Staff told us that when patients with a learning disability or who were living 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.
- Records indicated that 26% of all nursing and medical and dental staff providing outpatients services at the hospital had received level 2 dementia awareness training. The hospital had achieved commissioner's target of 25% for level 2 training. All staff have received level 1 dementia 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.
- There was sufficient equipment to provide support to people with mobility difficulties.

Learning from complaints and concerns

- 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

There were clear lines of management responsibility and accountability within the outpatient's department. The trust had systems which allowed gathering data, they were able to analyse it to identify risks and prioritise patients accordingly to clinical need. There were long term strategies drawn for individual departments and staff were aware of them. Staff felt that they could influence decisions made in relation to day to day running of their department and felt empowered by their management. There was a culture of openness and transparency. The hospital supported many research initiatives and participated in a variety of international clinical trials and research programs.

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 anything and they aimed to provide best possible services.
- 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 strength and weakness analysis was undertaken to identify risks and opportunities.
- Staff were aware of the challenges they saw to their own service such as an increased amount of referrals or environmental constraints. They felt they could participate in improving the trust's performance and patients' 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 systems to monitor performance and quality. Nurses and healthcare assistants working in the outpatient department told us that audits and quality improvement projects were discussed with the staff. Data collected by the trust was 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 speciality areas and 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 that they were listened to, and that they engaged in the development of the department.
- There were local risk registers for clinical imaging and diagnostic services and each of the specialities including medical 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 long time. For example, medical specialities' risk register indicated risk of causing harm, due to delayed care for follow up patients in glaucoma, cornea and paediatrics. It had been listed there since August 2009. There was also a risk of delay in providing care because of lack of notes availability, listed since September 2008. There were many long standing positions on the GRIDA risk registered including delays with histology results and reports in derma pathology due to poor IT tracking process, listed since June 2009.

Leadership of service

- We met with the outpatients' manager, the service manager and the matron. They were able to explain clear objectives for the development of the department. The management team had clear priorities in relation to the action plans in place to improve the appointment booking systems and also the access and availability of patient records.
- 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. OPD staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes. We were told that information was communicated effectively. Staff told us they were kept informed of trust developments and were aware of the challenges that the organisation faced. Staff who were managed outside of the outpatients structure were positive about their managers and the communication and leadership in place.

Culture within the service

- All staff we spoke to were very proud of their work. 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 very effective. Staff told us they felt able to raise concerns and discuss issues with the managers of the department.
- 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 procedure for reporting errors, near misses and incidents.
- The trust launched its "speaking up" campaign at the beginning of 2015. 650 staff 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

- Staff meetings were held monthly where staff were updated on upcoming events, audits, appraisals, mandatory training, and conferences, and achievements of the department were celebrated. Staff publications and posters prepared for conferences were discussed among teams. We saw examples of posters that were presented at conferences.
- Patients' views were obtained through variety of surveys including friends and family tests, and national cancer patient 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 hospital supported many research initiatives and participated in a variety of international clinical trials and research programs, such as those organised by The 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.
- The INPUT pain management centre provided a unique residential pain service.

Outstanding practice and areas for improvement

Outstanding practice

. We saw several areas of outstanding practice including:

- The use of 'Barbara's story' to engage with staff and enhance a compassionate approach to patient care.
- The specialist support units active within the urgent and emergency department including alcohol, toxicology, homeless, youth support and play therapy for children.
- The role of the security team in the emergency department was embedded into the day to day working of the department. The team was multi-lingual and trained in effective de-escalation techniques and demonstrated outstanding empathy to patients.
- The provision of 'reflection time' to staff within the urgent and emergency department.
- The approach to communication with and support of dementia and complex needs patients via well designed communication boxes and a specialing team.
- The ward environment and signage afforded dementia patients.
- The POP service (Proactive Older Patient).
- The multidisciplinary team support for families attending the neonatal unit.
- The paediatric cardiology service had introduced a home monitoring programme for infants following single ventricle palliation surgery (Norwood 1 operation or hybrid procedure). This allowed these patients to safely live at home with their families while they recovered and prepared for the second stage of their treatment.
- Supportive practice of the mortuary and bereavement team.
- The SPCT was effective and provided face to face support seven days per week, up to 9pm, with calls taken until 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.
- We saw 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.
- Staff in the emergency department had sourced funding and designed and produced a bereavement card that they sent to any families whose relative died in the department.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Improve the governance links between directorates with surgical activity to ensure learning and concerns are shared across these directorates in a timely way.
- Ensure that all women attending maternity department receive a venous thromboembolism risk assessment.
- Ensure that appropriate levels of midwifery staffing are available in all areas so that women are cared for in the most appropriate environment.

Action the hospital SHOULD take to improve

In addition the trust should:

- Review barrier nursing arrangements within HDU and ensure the environment meets infection prevention and control guidance
- Ensure that the full 'five steps to safer surgery' are embedded in operating theatre practice.
- Continue reviewing and improving cancer performance.
- Ensure consent is clearly documented and patients are given documentation of the process. Implement the recommendations from the consent audit 2014.
- Ensure all complaints are responded to in a timely manner.
- Where appropriate utilise day surgery more to reduce the length of stay.

Outstanding practice and areas for improvement

- Address areas of the national fracture neck of femur audit where the trust is performing below the national average.
- The hospital should ensure that staff are familiar with the mental capacity assessment process and that this is followed where appropriate.
- Ensure all staff are aware of safeguarding principles and triggers for making a referral
- Continue to increase consultant cover in maternity services
- Ensure that telephone advice given to women in maternity services is documented
- Ensure there is a system in place to check that HSA4 notifications of termination of pregnancy for fetal abnormalities are submitted to the Department of Health.
- The hospital should consider reviewing the tools staff use to assess pain and introduce a standard methodology that is consistently used and recorded.
- The hospital should consider reviewing the process for completing DNACPR form, determine a specific location where they are kept and ensure staff are aware they can be used as an interim measure on discharge until the primary care team can complete a new one.
- The hospital should consider reviewing the escalation process when delays occur with the completion of death certificates.
- 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 and clinical imaging departments ensure all staff are appraised regularly as prescribed by trust's policies related to staff training and development
- The hospital should ensure staff are aware how to arrange for an interpreter.
- The hospital should ensure that consultants review the results of local audits and implement strategies to ensure results continue to improve towards meeting CEM guidelines.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 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)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Not all women received a documented VTE assessment which was not in line with national guidelines or with local policy. There was a lack of clarify among staff about whether some low risk women in maternity services were expected to have a recorded assessment. 12 (2) (a)

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The midwifery staffing levels were not always sufficient to ensure women were cared for in the most appropriate environment. 18 (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.