King’s College Hospitals NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

King’s College Hospitals NHS Foundation Trust provides local general services and specialist care to the population it serves. King’s is well known for being an educational trust, and plays a key role in the training and education of medical, nursing and dental students with its academic partners, King’s College London and other local universities.

The trust is one of four major trauma centres, covering south east London and Kent. A new helipad at KCH opened in November 2016 to support the provision of trauma services. King’s is also a heart attack centre and the regional hyper acute stroke centre.

King’s College Hospital offers a range of services, including: a 24-hour emergency department, medicine, surgery, paediatrics, maternity and outpatient clinics. Specialist services are available to patients, which provide nationally and internationally recognised work in liver disease and transplantation, neurosciences, haemato-oncology and foetal medicine.

The Princess Royal University Hospital offers a range of local services including a 24 hour emergency department, medicine, surgery, paediatrics, maternity, critical care, and outpatient clinics. Services provided at Queen Mary’s Hospital Sidcup, and Orpington Hospital include care of the elderly, orthopaedics, diabetes, ophthalmology, oncology, and dermatology. The trust is one of four partners in the Academic Health Science Centre, King’s Health Partners, collaborating on world-class research.
The trust has 82 wards, with 1670 inpatient beds, of which 143 are critical care beds, and 97 are children’s beds. The number of outpatient clinics held each week is 3746.

The trust had 84,246 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 28,831 (34%), 6,187 (7%) were elective and the remaining 49,228 (59%) were day case.

The trust had 64,621 surgical admissions between April 2016 and March 2017. Emergency admissions accounted for 11,365 (18%), 13,116 (20%) were elective. There were 40,140 day case admissions.

The number of staff employed by the trust as of May 2017 was 11,878.

The boroughs of Lambeth and Southwark are below the national average (worse) for a number of public health indicators including; homelessness, deprivation, violent crime and poverty and notably obese children and sexually transmitted infections. The borough of Bromley is much less deprived with a number of indicators above the national average.

The trust was previously inspected in April 2015 where it was found to require improvements in a number of areas. As a result we took regulatory action, which included serving the trust with three requirement notices. A follow up focused inspection was carried out in October 2016 to check if action had been taken for some of the more serious areas of concern. Although we found improvements had been made in most areas we did not alter the ratings at that time.

**Is this organisation well-led?**

**Leadership**

Since the inspection of 2015 considerable change has been made to the leadership team, with new appointments to both executive and non-executive positions. The Chair, Chief Executive, Chief Operating Officer, Chief Financial Officer, Chief Nurse and Executive Director of Workforce Development had all been appointed to the trust following our comprehensive inspection of 2015, and all were substantive appointments.

Discussion with staff as part of pre-inspection engagement largely drew positive comments about leadership, such as; leadership was “good” and “healthy”. Staff felt the leadership team was now working together in a cohesive way; the team had a strength that had not been present before. Leaders were said to be more visible and approachable. The latter point was attributable to staff feeling more confident to approach the senior leadership team.

During the core service inspection staff who spoke with us more often than not expressed a positive perspective of the executive team and leaders, their level of engagement and drive for improvement. In particular the establishment of the leadership team at the Princess Royal University hospital (PRUH) had been positively received.

There was acknowledgement of the newer members of the senior executive team, who were taking time to get to known staff. The chief nurse was cited by staff in a number of core service areas as being held in high regard, and of being visible and supportive, as were the divisional leads. However, there was still an issue of lack of visibility from other executive leads. This was further compounded by the inability to directly access the executive team offices as a result of secure access arrangements. We brought this to the attention of the chief nurse who informed us soon after our visit, such restrictions would be reduced.
Inspectors who undertook the core service visits did not receive any specific or detailed information to suggest there were any concerns about the executive leaders. However, feedback from staff side suggested senior leaders were making decisions in isolation and not consulting the people on the ground who would be implementing the changes. They told us lots of work on the cost saving changes had been done over two years ago, and they had not received feedback with regard to this. Staff had been invited to be part of the discussion but had not seen their suggestions implemented or received feedback as to why their suggestions had not been taken forward.

The chair was held in very high regard by staff of all levels. It was apparent the chair had gained the respect of staff with people reporting their approval at how the chair promoted the highest level of probity and governance and of how he demonstrated the organisation's values and behaviours. Under his leadership the shape of the board was said to have changed to one where the right skills and vision was present at board level.

Non-executive directors (NEDs) voiced positive comments about the leadership including, having an executive team who were much more open and disciplined than before.

Patient governors gave examples where previously the executive team had been defensive when they were challenged. Now when they raised concerns, there was a more open culture. They felt there had been an enormous change in the last seven years in the way that governors were listened to and the leadership team were open to hearing what they had to say. They felt this was because there had been a complete change in the management and chair of the board, to the benefit of the organisation.

Governors felt there was gender balance in the executive team but commented on the lack of representation of the diverse ethnic makeup within it.

We found the trust had a senior leadership team with the appropriate range of skills, knowledge and experience. Our checks of formal documentation included fit and proper person reviews, appraisal information, recruitment processes and subsequent appointments indicated members of the executive team had a range of desired experience, knowledge and suitable fit for the needs of the services provided. Further, the range of organisational activities which have taken place and were in progress demonstrated a responsive and proactive leadership team.

The trust board was noted to be made up of individuals who had the appropriate range of skills, knowledge and experience to perform its role.

We were provided with detailed information pertaining to the external training programme and work shop activities which board members were involved in. This contained details of the objectives for the 18 month programme as a whole, the outputs from the previous leadership events held in March and September this year.

The leadership structures from an accountability perspective at the PRUH reflected that the hospital was a district general facility, with for example, a managing director, medical director, and director of nursing who acted as a triumvirate. This made them very visible, and the friends and family test (FFT) responses had showed a marked increase in accessibility of the executives at PRUH.

The divisional leads acknowledged the PRUH had been “run but not managed” in the past and staff were happy to have stability now. There was recognition by these leads that people had been
through a difficult period and it was now about stabilising the team. They welcomed and appreciated the diversity and sharing of information from staff since the changes and felt staff were really engaged with the leadership team. As a divisional team, they felt there was a good level of respectful challenge between the two divisional directors and managing director of PRUH and South sites.

Executive and divisional leaders were very aware of the challenges they were presented with, which included the financial position they were in; winter pressures, staffing, and the educational programme to support safety, effectiveness, career progressing and retention.

There were trust-wide objectives linked to firm foundations and strategic aims. These included areas associated with risk, such as finances and productivity. In addition, the executive leads had made four leadership commitments in July 2017. These were in the form of the four ‘Ps’; ‘our people, our patients, our partners, and our peers’. From this they had identified three top areas for improvement related to; team trust and respect, honest conversations and supporting the development and careers of staff, and leadership visibility and approachability.

The leadership was described by the chief executive as having “strong people in place”, and that it was, “starting to feel a powerful and functional organisation”. This was a result of three key drivers of change having been established by the trust.

In January 2017 the trust was reorganised into three divisions – Urgent Care, Planned Care and Allied Critical Services; Networked Care; and Princess Royal Hospital and South Sites. This leadership reorganisation was undertaken as a means of focussing on improving patient pathways, enhancing decision making, efficiencies, productivity and collaborative working.

Secondly, the leadership team had launched the ‘King’s Way’ in June 2016 as a means of changing the way the trust worked to improve the immediate and long term patient care. This had been successfully implemented on six wards, including a number at King’s College Hospital (KCH) and Princess Royal University Hospital, as well as at Orpington. A ‘Clean Sheet Redesign’ programme had been rolled out in nine areas of the trust. This used insight and data to create standardised care pathways and improve key operational processes.

The third element of leadership redesign included the King’s Academy. This was created to train staff and provide them with the four tools needed to look at services differently as a means of implementing continuous improvement in local and wider efficiencies, and overall quality.

We reviewed the trust leadership structure and noted this consisted of three distinct tiers; King’s Executive team, made up of 12 participants, King’s Senior Leadership Group, with 125 participants, and King’s Leadership Community, having around 200 members. The purpose of each tier had been defined along with the expectations of the frequency of meeting.

The Board had regular updates on activity at operational level and worked together on ‘Board days’ and strategy days, which were now being devolved to other management teams at all levels. Executive staff told us there was a healthy degree of challenge from the board members, and a genuine interest in all that was going on in the trust. The trust board and senior leadership team displayed integrity in their actions.

Non-executive directors commented on the timeliness of reports to the board, informing us the operations side were very good but financial less so, due to not having the time to do enough analysis.
A scheme of delegation of powers from the board of directors to officers of the trust was in place.

The Council of Governors reviewed and approved recommendations made by the Nominations Committee to appoint non-executive directors (NED). Respective NED took the lead for a number of areas as a Trust Board representative. Key roles and responsibilities were stated for each NED.

The trust had a lead for Child and Adolescent Mental Health Services (CAMHS) who also led on CAMHS liaison. The trust did not have anyone in the children’s safeguarding team who led on learning disability or autism, although they have such a lead in the adult team. In the event of a child presenting with these challenges and safeguarding concerns, the staff would work with the child’s allocated social worker in the child with disability team, their education provider and health care provider, including GP and community nurses.

The executive had agreed a ‘Talent Management’ approach for succession planning where executive roles were to become vacant. The aim was to “grow from within, so that 70% of the positions that became vacant would in the future be filled by internal staff, with the remaining 30% recruited externally. Work was in progress to develop this process, including the design and testing with stakeholder from across the organisation.

The trust had developed a talent and succession strategy, which was launched this year. This included a focus on the likely turnover of staff in the next five year, as well as avoiding bringing temporary leadership in.

When senior leadership vacancies arose the investment board and recruitment team reviewed capacity and capability needs. We noted that such vacancies were managed via an external recruitment agency, with a formal programme of activities to support the process at each stage. This included ensuring the leadership style of applicants matched with the trusts vision and values.

The trust reviewed leadership capacity and capability on an ongoing basis. This was undertaken via a number of methods, including individual performance review and service related outputs.

The Chair received a formal annual appraisal in accordance with the NHS Foundation Trust Code of Governance and the trust’s own policy.

Our discussions with members of the trust leadership team determined they had a comprehensive knowledge of the current priorities and challenges, including those of a financial nature. The latter was particularly challenging and whilst there was a longer term financial recovery plan, there remained enhanced scrutiny by NHSI.

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priorities. These values drove the organisation and commanded a high level of respect in the wider community.

The vision and values had been developed and consulted on trust wide and were supported by the Trust Board. Staff who spoke with inspectors during the core service visits confirmed they understood the vision and values. There was awareness also of local strategies in most cases.

The chief executive indicated the senior leaders modelled the vision and values, and there were formal structures within clinical and operational areas, which enabled these to be embedded across service divisions. Frequent reference to the vision and trust values was reinforced through general communications and visibility of key staff, including the chief nurse.
An operational plan for 2016/17-2017/18 outlined in detail the intentions for finance, activity and workforce, with a focus on delivering achievable improvements in these areas.

The aforementioned plan was robust and supported a realistic strategy, which was to; ‘provide outstanding services to patients and increase our reputation as a world-class centre for specialist clinical, teaching and research excellence’, and for achieving the priorities and developing good quality, sustainable care.

In terms of the organisational strategy fitting with the Sustainability and Transformation Plan for South East London (STP), NEDs indicated it was not yet there. The focus had been on the next two-three years but it was recognised the trust needed to be looking at the next 10 years. They added there were a number of strategies which were not interwoven across the organisation as yet. However, they could now see a way through with the institutes and King’s Health Partnership (KHP).

There was some progression with community partners, although NEDs reflected pace of change could be accelerated to ensure service improvements and care pathways had more timely positive impacts on service users. The new strategy director was starting the week after our inspection and it was anticipated they would progress the wider implementation of system wide change in conjunction with other health partners.

The trust was able to report on progress made with respect to six quality performance targets set for 2016/17. The King’s College Hospital NHS Foundation Trust Quality Report & Accounts 2016/17 we reviewed provided detailed information on successes and areas where further work was required. Building on from this, the executive team has identified in conjunction with local stakeholders seven priorities for 2017/18 for improving quality, as outlined here:

- Enhanced recovery after surgery (ERAS) in surgery of the liver, gallbladder, bile duct and pancreas (‘hepatobiliary’ (HpB) surgery).
- Improving outcomes after emergency abdominal surgery.
- Improving the care of people and children with mental, as well as physical, health needs at KCH.
- Improving outpatient experience for children and adults.
- Improving the experience of patients and their families with cancer.
- Improving the implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis.
- Improving the quality of surgical safety.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The clinical site strategy had patient and governor involvement. This was at a piloting stage with elements in place, and it was acknowledged by NEDs that it could not be something they did alone.

The key priorities of the trust regarding medicines optimisation were outlined in the Medicines Optimisation Strategy and business plan, which was commissioned by the Trust Board. Staff knew about the strategy as it was shared in various team meetings and in 1:1 discussions (for
example, during appraisals). Two of the elements of the strategy linked to values; what were medicines used for and workforce efficiencies and safety.

The trust had taken part in the Carter review and acted as a host STP lead. Medicines issues were discussed at the DTC or at the Medicines Safety Committee (MSC). The medical director (who also chaired the MSC) line managed the chief pharmacist and this ensures that pharmacy issues are communicated regularly to the senior leadership team via the Executive and Quality Committee.

The trust considered and adopted relevant guidelines and proposals relating to medicines optimisation chiefly via the Drugs and Therapeutics Committee in order to approve relevant guidelines. These were then fed upwards via the Patient Safety Committee to the Executive & Quality Committee to gain trust wide recognition and approval.

Staff spoken with during the core service and well-led inspection knew and understood the trust’s vision, values and strategy, as well as local strategies. They understood how achievement of these applied to the work of their team.

Information reviewed by us including communication material sent to staff demonstrated the vision, values and strategy were embedded in every day actions.

Finance Committee reports we viewed indicated the trust was reporting a deficit of £48.7 million, an adverse variance from plan of £3.5 m. The true operating deficit was reported in month five as £51.2 million due to an advance payment of £7 million from the Fetal Medicine Foundation. The report discussed key issues related to income and expenditure amongst many other factors.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. King’s is part of the King’s health partnership (KHP), which includes other trust in south East London. KHP is a key driver of specialist service development. The commitment within the partners of the STP was to continue to improve services for the residents of South East London within the resources available.

The trust had planned services to take into account the needs of the local population.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

One of the clinical priorities for 17/18 was improving access to mental health services for both adults and children. The trust had a strategy for meeting the needs of patients with a mental health, learning disability, and autism or dementia diagnosis.

**Culture**

Executive team members, the chair and NEDs spoken with during the inspection reported feeling very proud of their colleagues and staff in general. The “people are amazing” typified comments made to us. The executive team were described as “excellent.” The chief executive told us it was “fantastic to have executive leaders as well as divisional leads who are tremendous.”

The majority of staff spoken with during the core service inspections felt respected, supported and valued. The trust recognised staff success through staff awards and through feedback. There were dignity awards for staff that went the extra mile in patient focussed activities. For example, we
were told about an elderly care ward at PRUH where staff had brought in records and held a tea party.

The trust’s strategy, vision and values underpinned a culture which was patient centred, although it was acknowledged there was also a heavy focus on savings. The chief financial officer told us weekly executive meetings were dominated by money but there was time to focus on performance and quality, staff morale and feedback from patients, family and friends.

We found in our core service inspections and subsequent discussion within the well-led review, staff were encouraged and supported to raise concerns and report matters which impacted on patient safety and quality of services. There was a culture of being open and honest, supported by practices and professional guidance. This included a policy on raising concerns, when the interests of others or the trust itself were at risk.

The trust applied duty of candour appropriately, as evidenced within our review of documents pertaining to adverse events and serious incident investigations. They took appropriate learning and action as a result of concerns raised, and were open and honest in their communications to individuals concerned.

Although there was a sense of an improving culture, it was acknowledged by NEDs that “until they get engagement right the culture would not change”. For example, there was recognition that a change in culture was required with regard to supporting the achievement of activity within theatres at PRUH. Board reports indicated a decline in activity with ‘dropped’ lists and increase in cancellations. The reason for this was said to be complex, such as not being able to get anaesthetists and matters of equity regarding payment. The transformation team had been charged with looking at the local culture in this area.

It was recognised by members of the leadership team that each hospital site had its own identity and the demographics were different. As a means of improving the shared culture across both the two main hospitals there was considerable effort to reinforce cross site working. Board meetings were now held alternate months at the PRUH. As well as attending meetings at PRUH, and rotation of executives, leaders from KCH met with their opposite number at the PRUH. Staff reported the chief nurse as being very visible.

Although the majority of staff spoken with felt positive and proud about working for the trust and their team, there was a degree of variation across staff groups. Staff spoke of feeling senior staff at PRUH were doing much better than at KCH with regards to improving the culture. Staff spoke about the ease at which they could talk to the Managing Director of the PRUH and South Sites, and how they listened to their concerns and tried to do something about them.

There were mechanisms for career development conversation. A Talent Management (TM) Stakeholder Group Workshop was held on 11th January 2017. This provided attendees with the opportunity to explore a number of elements related to this area and develop the next steps, for example; the talent identification process needed to be easy and clear enough to be used at every level of the organisation, succession pools would need to be identified across the organisation, there would be a need for coaching and training in conversations, and re-branding talent management as career development.

The members of the trust’s staff side committee did not feel that the trust worked appropriately with them, staff side felt that the executives did not engage with them in a timely manner, when staff side requested involvement they were often invited to discussions at a late stage, which they felt prohibited them from being able to contribute in a meaningful manner.
Staff side representatives told us they did not feel supported in their roles and told us they were not given dedicated time to fulfil their duties within the staff side committee. There were 14 unions with representatives but there were only six in attendance, we were informed that this was due to workloads and was a regular occurrence. No Drs in attendance.

Managers had policies and procedures to enable them to address poor staff performance where needed. Where relevant associated best practice, such as the Advisory, Conciliation and Arbitration Service (ACAS) code of practice on disciplinary procedures and the Employment Act 2008.

NHS Staff Survey (2016) Performance on questions relating to bullying, harassment and equal opportunities

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Trust 2016 Average (median) for acute trusts  Trust 2015
KF25  Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
White 39%  27%  35%
BME 33%  26%  32%
KF26  Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
White 30%  24%  29%
BME 34%  27%  31%
KF21  Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
White 84%  88%  82%
BME 65%  76%  87%
Q17b In the 12 last months have you personally experienced discrimination at work from Manager/team leader or other colleagues?
White 8%  6%  6%
BME 17%  14%  5%

(Source: NHS Staff Survey 2016)

NHS Staff Survey Performance

In the NHS Staff Survey 2016, the trust performed better than other trusts in two questions, about the same as other trusts in 14 questions and worse than other trusts in 18 questions.

The questions for which the trust performed better than other trusts were:

Quality of non-mandatory training, learning or developing (4.11 compared to the England average of 4.06)
Recognition and value of staff by managers and the organisation (3.34 compared to the England average of 3.45)

The questions for which the trust performed worse than other trusts were:

- Staff satisfaction with level of responsibility and involvement (3.83 compared to the England average of 3.92)
- Staff satisfaction with resourcing and support (3.15 compared to the England average of 3.32)
- Response rate % (36% compared to the England average of 43%)
- Effective team working (3.65 compared to the England average of 3.75)
- Percentage of staff working extra hours (77% compared to the England average of 71%)
- Percentage of staff appraised in last 12 months (73% compared to the England average of 86%)
- Support from immediate managers (3.63 compared to the England average of 3.73)
- Percentage of staff suffering work related stress in last 12 months (44% compared to the England average of 35%)
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (41% compared to the England average of 31%)
- Organisation and management interest in and action on health and wellbeing (3.38 compared to the England average of 3.6)
- Percentage of staff satisfied with the opportunities for flexible working patterns (43.54 compared to the England average of 50.51)
- Staff confidence and security in reporting unsafe clinical practice (3.60 compared to the England average of 3.66)
- Percentage of staff experiencing physical violence from patients, relatives or public in last 12 months (17% compared to the England average of 15%)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months (35% compared to the England average of 27%)
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (32% compared to the England average of 25%)
- Percentage of staff reporting good communication between senior management and staff (25% compared to the England average of 33%)
- Percentage believing that trust provides equal opportunities for career progression or promotion (76% compared to the England average of 86%)
- Percentage of staff experiencing discrimination at work in the last 12 months (19% compared to the England average of 12%)

The engagement score for this trust was 3.74, which was below average for NHS acute trusts.

(Source: NHS Staff Survey 2016)

Bullying and Harassment was described by the director of workforce as a big worry for the trust. The trust had introduced a number of processes to start to tackle this. The Head of Equality & Inclusion had spoken to staff about their concerns across service areas. Themes arising from discussion indicated it was as much about the message conveyed, as well as behaviours of staff.
The chief nurse described some of the actions taken to address bullying and harassment, which included having a designated senior staff member who focused on staff being cared for and nurtured. Results were already being seen as measured through the friends and family test (FFT) score, which had significantly improved.

Our discussion with the director of medical education about bullying indicated the numbers of reported incidents had been reducing year on year. In the induction programme, time was dedicated to expressing zero tolerance of this. If any such behaviour occurred the doctors emailed the director of medical education directly. He then worked with the perpetrator to make sure it did not happen again. We asked what the themes had been if any and were told most occurred in response to stress and pressure.

Our discussion with representatives from staff side indicated a perception of bullying, including between managers. The main issues and concerns for staff/members that were being raised through staff side related to bullying and harassment, lack of staff development and on-the-job training, staff numbers, retention and recruitment. We were told some administrative staff felt they were very badly treated, and if they raised their head above the parapet, “you are then a goner”. Because of this some staff did not always feel able to raise concerns without fear of retribution; however we did not receive any indication of these concerns during the inspection or during the staff drop in sessions held prior to the inspection.

The King’s College Hospital Diversity and Inclusion Matters Strategy Document, 2016 to 2020 noted the diversity in the workforce with 44% of employees declaring themselves from a Black Asian and Minority Ethnic (BAME) background. At the same time the strategy indicates a need for the trust to challenge itself to ensure that diversity and inclusion is embedded in the culture, with increased visibility to patients and staff.

The 2016 NHS staff survey results showed that discrimination on the ground of ethnicity was higher than other protected characteristics covered in the Equality Act 2010.

One of the six work streams arising from the staff survey results and need for improvement related to diversity and inclusion. Each work-stream was required to meet every month as a minimum. The Diversity Work Stream Group was chaired by the chief nurse.

We noted the Annual Workforce Equality and Diversity Report for July 2016 contained a breakdown of the workforce equalities data and key trends, as well as the Workforce Race Equality Standard (WRES) data for 2016. Within the report the trust had set itself two objectives; to fully implement the Workforce Race Equality Standard (WRES) 2016, and to fully implement the Equality Delivery System 2 (EDS2). (Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the ‘9 Steps for EDS2 Implementation’ as outlined in the 2013 EDS2 guidance document.

Actions arising from these two objectives was evidenced in the ‘workforce diversity and inclusion metrics’, which were discussed at the Education Workforce and Development Committee. A summary report on progress against the workforce race equality standards (WRES) improvement measures and nine EDS2 indicator areas had been presented to the Board.

We reviewed the WRES results for March 2016 and those for March 2017. We noted in March 2016 there were 5,016 BME staff employed, which increased slightly to 5,142 in March 2017. Of these staff members 141 (2.8%) and 80 (1.5%) respectively entered the formal disciplinary process. This compares with 1.24% and 0.8% of the white work force for the same period of time.
The percentage of staff experiencing abuse, bullying or harassment by other staff in the previous year indicated for white employees, 29.2% as of March 2016 and 30.4% for March 2017. For BME staff the figures were 30.6% and 34.3% respectively.

With regard to equal opportunities for career progression and promotion the figures for BME staff agreeing with this were slightly above those of white staff responses in March 2016 (86.6% and 81.6%). However, the picture was worse for March 2017, 65% for BME staff versus 83.8% of white staff.

Workforce Race Equality Standard Improvement Plan for 2016 – 2018 outlined the areas which the trust aimed to address, how it would be achieved, what success would look like, the person responsible for the action and target date for achievement.

The EDS2 grading had been completed by the trust in September 2017. We noted with regard to the measure; Fair NHS recruitment and selection processes lead to a more representative workforce at all levels no grading had been applied. Whereas two other measures; The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations, and; training and development opportunities are taken up and positively evaluated by all staff, were both graded as achieving. We noted too no grading for the other measures related to the goal of having a representative and supported workforce. The three measures used to assess inclusive leadership either scored achieving or developing.

The trust had three distinct staff networks with associated terms of reference, and details on their purpose and frequency of meetings. These were; the Lesbian, Gay, Bisexual and transgender Forum (LGBT), the Cultural Diversity Group (CDG), and the Disability Inclusivity Network (DIN).

Since the previous comprehensive inspection the BAME network had been reinvigorated, although its launch was not carried out at the same time on both sites. This contributed to a feeling among some staff of Denmark Hill first, PRUH second.

There was a board champion for ethnicity and diversity. Staff acknowledged the recently established BAME network, although at the time of the inspection it was too early to consider the impact of the BAME network.

The trust recognised the lack of ethnic diversity in the board membership. They had recently launched a reverse mentoring scheme in order to find out what it was like as a BAME member of staff working at the trust.

We were told there was an improving picture with regards to appropriate and fair employee relations. The manager’s guide was described as “good” but there remained a lack of training for managers, however, they had just launched leadership and development training for managers to address this issue.

The trust appointed a Freedom To Speak Up Guardian in February 2017 with an associated committee being launched in May 2017. The post holder had one day per week for related activities. Terms of reference for the role were in place and the associated policy had been changed to include a manager’s guide within it. The policy was clear that a formal investigation could be instigated where necessary.

A non-executive director acted as chair on the Freedom to Speak Up Committee. There was a degree of inconsistency in the number of FTUU ambassadors. NEDS told us there would be 15 once all appointed but we were told by others there were 10 ambassadors at present with a further nine expected to have completed their training by the end of December 2017.
The ambassadors had not yet gone live but were from different specialities, including six nurses, three doctors, and one each from administration and student nursing. Recognising the need for more diversity in the role, the trust was encouraging representation from BAME and LBGT communities to ask them to become ambassadors.

There had been 10 contacts from staff at the time of inspection via the FTSUG, all of which came from KCH staff. Bullying and harassment had been cited in six cases, one related to patient safety and skill mix in theatre, one senior doctor behaviour, one inappropriate behaviour and one about leadership. The NEDs advised us they had not yet had any feedback on the cases, although the FTSUG told us four cases had been closed. No decision had been made as to whether the concerns were to be taken to the open or private board. Concerns related to executives or board members were to be taken externally. Information from the FTSU Committee was expected to feed into the board quarterly. At the time of our inspection meetings were adhoc, and although invited, staff side had not yet sent representatives to any of these.

It was recognised by the FTSUG piece of work about managing the expectation of the expected outcome needed to be done. They did ask the individual what they wanted out of the respective meeting but it was about being realistic about what could be achieved.

Staff knew how to use the whistle-blowing process and about the role of the Speak up Guardian.

The trust had workforce strategy for the period 2016-2019, which set out the priority areas, goals and objectives and how these would be addressed. It had been acknowledged by the trust the strategy needed to be aligned with the priorities of the London Workforce Strategic Framework, Our Healthier South East London Workforce Supporting Strategy Programme and the SE London Sustainable Transformation Programme (STP), whilst addressing external factors.

A series of engagement events had been carried out, the first of which was in 2015, followed by a workshop in February 2016, discussions at the Education and Workforce Development Committee in January and March 2016 and the Board in March 2016.

The resulting strategy included aims and outcome measures, a number of which would be demonstrated via the National Staff survey.

Training and progression was described to us as segmented across the equality strands. However, the trust had done a lot of work on career development with nurses. This included the introduction of the Nursing Talent & Career Management Approach at King’s, which took place in June 2017. A nurse development tool was now in use, recognising the need to be more systematic, with the design of a talent strategy for career development, and growing from within the existing workforce.

A member of the executive team described resourcing as a waterfall, which showed the movement for the nursing progression up and out. Promotion at Band 5 to Band 6 had been an issue, which was now being addressed by the development of a nurse progression tool. The executive director of workforce development told us she was able to see from the tracking of promotions that these had increased internally. Further work was in progress tracking the grievances raised and actions taken by the manager.

The NHS staff survey 2015 and 2016 indicated that 73% of staff reported having had an appraisal in the previous year. The trust reported to pre-inspection the combined medical and non-medical staff (rolling percentage) was just over 45% as of May 2017. Combined medical and non-medical appraisals rate was 63% at the time of inspection. The core service inspections identified a small number of individuals who had not had an appraisal for some time and delayed appraisals in a few departments.
A modernised approach to appraisals was subsequently put in place, with the emphasis on regular high quality conversations with Staff about their delivery and development, and the method to report an appraisal was being significantly simplified. This included the following: removing the link to incremental pay, aligning all staff objectives to the strategic priorities of the trust, focusing on conversations and provision of an online or paper based option to record this, focus on achievements, valuing staff and recognising the contribution they make, providing an equal rating on what was achieved and how it was achieved, and transferring the online appraisals from the current system (KAD) to the new Learning Management System (LEAP).

Staff within the pharmacy team had regular appraisals and the pharmacy staff survey results were analysed to look at the results from the pharmacy team. Staff concerns were able to be collated via informal and formal means, for example, a ‘graffiti board outside the Chief Pharmacist’s office. As a result, and in conjunction with the Carter review, they pharmacy department had developed an advisory board that was led by the workforce, with the chief pharmacist seeing each group of staff every three months.

Staff had access to support for their own physical and emotional health needs through occupational health. Also available were monthly forums for all grades of nurses and health care assistants. These provided opportunities for discussion, support and shared learning.

The board received information in a formal report pertaining to staffs health and wellbeing. The 2016 report outlined the trusts strategic approach to staff health and well-being, linked to the Trust Strategy and the Workforce Strategy.

With respect to staff health and well-being, there was a specific page on the intranet ‘Kwiki’ site that provides some information to staff. A variety of interventions, support and initiatives have been provided to staff through occupational health, human resources and staff volunteers including; physiotherapy, an employee assistance programme, counselling, smoking cessation. In addition, six ‘Mindfulness’ courses were provided as part of the King’s Health Partner’s staff health and well-being group. There were annual staff health and wellbeing events including health checks to attendees, Flu vaccinations and mediation service.

The trust’s sickness levels between June 2016 and May 2017 were lower the England average. There was a small spike in January 2017 and a dip in April 2017. However the trust was fairly consistently around a 3% sickness level.

(Source: NHS Digital)

Although no supporting evidence was provided to us, staff side representatives told us people were not enabled to move on in their careers. They added that people were brought in from outside when someone in the trust could do that job.

**Governance**

The trust had effective structures, systems and processes to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures.

The Trust Board met regularly and provided an opportunity for scrutiny to members of the public as well as internally. Meetings were held in three parts, the first in public, followed by a ‘Go, See’ walk around. The Board then met in private. At the beginning of each board meeting there was a patient story. A patient and the staff that were involved with the care of the patient attended the board meeting to provide a narrative on their patient experience. The Board then discuss the learning from this. The addition of the patient story at the Board was considered by all in
attendance to be a powerful and often emotive session. Both executive and non-executive
directors told us they considered patient stories were essential to helping the board focus on
improving services and for ensuring trust services were centred on the needs of people using
services.

We attended two board meetings and found these were effectively chaired. The meetings ran to
time and all the agenda items were covered and were given due regard. We observed during our
participation in the “Go, See” visits they provided a monthly opportunity for board members to visit
different departments within the hospitals, to talk to staff and patients about their experience. A
member of staff from each department escorted the board members during these visits.

Papers for board meetings and other committees were sufficiently detailed. Minutes of such
meetings were recorded and made available as appropriate.

Non-executive and executive directors were clear about their areas of responsibility. Job
description and role profiles reviewed during the inspection provided clarity of responsibilities and
specific requirements.

Non-executive directors told us there were firm foundations of governance, with focus on cause
and effect. Pressures to make efficiencies had made them less internally focused and more aware
of the need to look to the community and population served. This had created a whole new set of
relationships and the sustainability and transformation partnerships (STP). For example, we were
told all the managers and clinicians from PRUH relating to frailty came in to talk to the board,
recognising that performance was a system wide issue.

The KCH site had a service level agreement with South London and Maudsley NHSFT to provide
Mental Health Act expertise in order to ensure processes and codes of practice were adhered to.
Clinical site managers received all paperwork on behalf of the trust and ensured this was correctly
completed. Regular daily (working hours) supervision and adhoc training was provided by the
MHA office.

Appropriate governance arrangements were in place in relation to Mental Health Act
administration and compliance. Mental Health Steering Group Minutes demonstrated evidence of
discussion around various relevant areas.

The trusts governance framework addressed the need to meet people’s mental health needs.

Monthly Mortality Committee meetings provided staff with the opportunity to review all elements of
the patients’ journey within the appropriate division, this included reason for admission and the
treatment and care provided, and any associated contributory factors leading to an adverse
outcome or death. Learning points arising from the review process were identified and
communicated formally through presentations.

The divisional leads told us that under the PRUH triumvirate there were care groups, each of
which had its own triumvirate. They had their own governance forums which feed up to the
divisional governance committee and then up to the QARC, and further to the board.

A clear framework set out the structure of ward, team, division and senior trust meetings.
Managers used meetings to share essential information such as learning from incidents and
complaints and to take action as needed.

However, there were some inconsistencies in the way in which some care groups undertook
review of risk and governance. For example, the minutes for the Urgent Care Group Risk and
Governance meeting was significantly more detailed and of better quality than the surgical care
group at PRUH. One clinical initiative for the trust was to improve surgical safety; however, WHO
checklists was only discussed in the May 2017 meeting, despite it being a standing agenda item. There was no discussion of risks or complaints within the surgical minutes.

The executive quality board provided an opportunity to review all adverse events and from these ‘safety net’ posters were generated and circulated. For example, an incident related to the incorrect syringe used for insulin. Within 24 hours the safety net poster was circulated.

We were told in our discussion with the pharmacy lead there was pharmacy leadership in all the care group meetings. From such meetings they had to collate all the relevant pharmacy based statistics (i.e. safety thermometer dashboard metrics) from the four different sites. They then produced a summary for the Executive and Quality Committee, ensuring the committee gained a ‘safety’ view of how the organisation was performing with regards to medicines safety.

Medicines optimisation was well integrated into the governance structure for the trust. Medicines incidents reported on the Datix system were discussed at the Medicines Safety Committee. The committee had a clear and manageable remit and was effective in monitoring medicines incidents, investigations and the sharing of learning.

The Drugs and Therapeutics Committee were responsible for authorising all medicines related NICE Guidance and Technology Appraisals and this was fed back to the Executive and Quality Committee. Patient Group Directions were reviewed and updated by a group chaired by a non-medical prescriber. This also included maintaining a register and the overview of Patient Specific Directions. There were no gaps seen or reported in the reporting lines between the medicines related committees.

The Quality Assurance and Research Committee produced a Research and Innovation report, a copy of which we reviewed for 2016/17. We noted the governance processes included incident reporting and investigation, with analysis by the trust governance lead and research and innovation lead. Incident trends and lessons learnt were reviewed by the research and Innovation Committee, and major breaches were subject to review and signed off through the same committee, which was chaired by the medical director.

The trust had commissioned an independent review of the governance processes, a report of which was provided in July 2017. We noted the report concluded there was significant assurance around governance with only minor improvements in the areas of ‘consistency and regularity of reporting to relevant parties involved in the processes.

The head of patient engagement and patient experience reported every quarter to the board and main committees, which included; the QARC and Patient Experience Committee. Action plans were reported on monthly to the divisions, including a break down by ward.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements.

Management of risk, issues and performance

The chief executive was the accountable officer, and as such had responsibility for ensuring an effective risk management system was in place. The executive medical director (MD) was designated as the individual responsible for leading on patient safety and risk management. In addition, the chief nurse, in conjunction with the MD was required to maintain an overview of clinical governance arrangements, which included the reporting, management and investigation of
adverse incidents. We observed other key staff had responsibilities outlined within the trust’s policy for the ‘Management, Reporting and Investigation of Adverse Incidents’ (2010).

The chief financial officer had a joint responsibility on the Trust Board, which also included his role as the Senior Information Risk Owner (SIRO). A SIRO brief was held once per month and included a case review and other discussion related to the protection and use of information.

The trust was required to report against a core set of performance indicators using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. We reviewed information which had been reported in the King’s College Hospital NHS Foundation Trust Quality Report & Accounts 2016/17 and noted this was sufficiently detailed to provide assurance of results and actions.

King’s College Hospital Clinical Quality Review Group Meeting minutes reviewed by us indicated participation of representatives from Bromley, Lambeth and Southwark Clinical Commissions as part of the STP. This included for example, the GP clinical lead, safeguarding lead and head of quality. We saw too representation by NHSE. The meeting notes indicated detailed discussion around various areas related to risks and performance, including for example; progress on various actions, such as infection prevention and control and cancer services. Patient outcomes, safeguarding, and deprivation of liberty safeguards amongst other subject matters were also discussed, and actions agreed where relevant.

The trust had a system for the management of medicines safety alerts. This process was overseen by the trust Medicines Safety Committee. Action plans were produced and copies of the trust medicines incident policy were accessible to staff via the intranet. Staff across the trust knew how to use the Datix® system to report medicines incidents. All medicines incident reports were sent to the pharmacy department to review. Outcomes were discussed with team members, including prescribers and ward pharmacists, along with training bulletins sent out to wards. This ensured that learning was disseminated to all staff.

Our review of the end to end process for a number of series incident reports and complaints made by people who used the services at the trust indicated a robust system. This had contributed to the identification of improvement through shared learning.

Information we reviewed and our discussion with the safeguarding lead indicated there was evidence of good practice in this area of risk. This included joint working between the trust and external agencies in order to achieve positive outcomes for patients.

Learning as a result of an audit with respect to safeguarding multi-agency working had been shared with staff via the ‘Child Health Safeguarding Children Bulletin’, September 2017. Lessons learned and recommendations made were highlighted. We noted safeguarding alerts were subject to a level of review and improvement. The governance team regularly reviewed the systems.

Senior management committees and the board reviewed performance reports. For example, the director of Infection Prevention and Control (DIPC) chaired a monthly Healthcare Associated Infections meeting with various representatives, including those from the external agencies providing cleaning services, and Public Health England. Information from such meetings was communicated to the Public Board of Directors and trust Board in the Quarterly Patient Outcomes Report. Other performance reports presented included; Quarterly Patient Safety Quality Assurance & Research Committee (QARC) Chair’s Update and the Safeguarding Report – Children.
The QARC had monthly updates on activity in all the sites and in all departments. We were told by a NED that this same committee ‘kept an eye’ on equality and diversity and they were very pleased with the multi ethnic days where different religions were celebrated.

Leaders regularly reviewed and improved the processes to manage current and future performance. This was evidence in the discussion of information via the Public Board of Directors, including the overall Performance report; Finance report, Finance & Performance Committee Chair’s report, the Council of Governors report and Board Committee.

The trust had a Cost Improvement Programme (CIP), which included various work streams related to departments and activities. The CIP Efficiency Board met weekly to consider projects with a green status. Performance and quality reports were triangulated to see if the CIP had contributed to any adverse outcome. The board were described as “challenging” with regard to any red rated CIP, as this indicated an area of non-performance financially, generally related to income generation. There was a clear awareness of areas which were behind for income generation, including those that could not be influenced by the trust, such as road traffic incidents.

Integrated score cards provided detailed oversight of performance in a number of areas. For example we reviewed results for the period August 2016-August 2017 with regard to quality of care associated with safety and effectiveness, and quality of care related to access. Other areas scored included; skilled, motivated, can do team, top productivity, finance, teaching and research. Scores were red, amber and green (RAG) rated.

We noted the main areas with consistent red scores were those for access, particularly referral to treatment (RTT), operational flow and the number of un-outcomed RTT appointments. There were a significant number of red scores assigned to safety elements of antibiotic stewardship and the care of intravenous lines. The latter mainly related to documentation and duration of the line being in situ.

The trust had a Risk Management Strategy, which stipulated that the Quality, Assurance and Research Committee received and reviewed all risks graded 12 or more on the trust-wide risk register. This was to be done on a quarterly basis.

The trusts Patient Safety Audit Programme was noted to provide a degree of assurance that areas identified as high risk were routinely reviewed and any necessary improvement taken accordingly. The programme formed part of the Risk Management Strategy, with audit activity reporting via the Patient Safety Committee to the Trust’s Quality Governance Committee. We observed 22 specific audits identified within the programme.

The trust had an action plan arising from the Savile Enquiry Report published in February 2015. Actions were aligned to the recommendations and progress was clearly stated.

A full audit programme had been identified and this reflected the Department of Health and Healthcare Quality Improvement Partnership (HQIP). Many of the audits which had been completed since our previous comprehensive inspection were awaiting publication. A number were in progress at the time of this current inspection.

The trust also participated in NCEPOD Studies and national audits. The latter results had been reported in the King’s College Hospital NHS Foundation Trust Quality Report and Accounts for 2016/17.

We reviewed the aforementioned report, and noted the information for the national audits indicated a descriptive and colour coded definition, such as a green for positive analysis: That was where the outcome measures were better than or within expected range; underperformance against
<50% process targets with no demonstrable impact on patient outcome. A yellow/neutral analysis was attributed to the results where outcome measures were within expected range; underperformance against >50% process targets with no demonstrable impact on patient outcome. Methodological issue, including the sample being too, small, sample not representative, or results did not provide a measure of performance, were noted to be blue. According to the information presented there were no negative (red) outcome results across PRUH or KCH.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. The balance score card provided a degree of confidence in recognising concerns or risks early. Teams acted on results where needed and there had been improvements in key measures related to clinical outcomes, such as surgical safety, sepsis and local issues of quality. The chief executive reported to us feeling satisfied there was a “tighter grip” related to the quality of services at the front line.

The trust advised us there were over 1300 pieces of National Institute for Health and Care Excellence (NICE) guidance which required review, and monitoring compliance with each piece of guidance was said to be appropriately ‘owned’ by the clinical areas. A central record was kept of the confirmation from the clinical lead that practice adhered to NICE. Exceptions such as the inability to implement NICE guidance as a result of resourcing issues, or disagreement with the guidance were reported to the Patient Outcomes Committee.

The quarterly Patient Outcomes Report included information on the level of compliance with NICE guidance. This report was then shared with the executive-level and from there to the Board of Directors. Information was also sent to the commissioners via the Commissioning Quality Review Group.

During the core service inspection we identified a scenario around the use of tranquillisation and the monitoring of patients, which did not reflect the recently revised NICE guidance. We raised this as a concern with the trust and were provided with a formal response as to the particular concern and immediate actions taken, and those for further development.

There were clear examples of action taken to address areas of concern which had impacted on the quality of patient care. The Commission was made aware of by the chief nurse and kept informed of a particular situation, which had resulted in the closure of a ward because of concerns regarding quality and patient safety. Actions taken included additional training and support for staff, and an upgrade to the environment.

We had confidence that where matters of concern were brought to the Commissions’ attention and then communicated to the trust, action was taken to investigate and make improvements. This was demonstrated through the feedback we received as well as formal recording of actions taken within incidents we reviewed during the inspection.

Since April 2017 the trust had a more rigorous process of assurance that the duty of candour had been applied. There had been 420 reported incidents where there was moderate harm, severe harm or death reported. We saw examples where the duty of candour was applied. In addition, we reviewed audit results for the period April to June 2017, which showed the following high level of compliance: Disclosure was made and a discussion recorded in 96 out of 107 cases (90%). An apology was provided in all those cases. Written notification was provided in 91 incidents (85%). One patient declined the letter and report which were shared with the patient’s consultant who had reported the incident (1%). In addition to the 10% where the conversation was not documented, a further 4% did not have evidence of a letter being written. From the data, it was recorded that in 23% cases the investigation findings had been shared. A large proportion of the incidents were still being investigated and report findings were due to be shared on completion.
Divisional triumvirate, clinical directors, heads of nursing, general managers and the patient safety and risk managers had responsibility to oversee and manage their risks. Corporate risks were the responsibility of the director leading in the respective area. Each of the three divisions had divisional risk and governance meeting’s where their risks were reviewed at least quarterly. Deep dives were presented by care groups periodically in order to provide details of the respective risks.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. The trust had a pharmacy risk register. Current concerns voiced by the Chief Pharmacist included a national shortage of medicines available to be procured and also the lack of availability of licensed medicines for specific complex conditions to be treated. This had led to the sourcing of unlicensed medicines in these conditions as a risk mitigation process.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Staff concerns identified in the core service inspection matched those on the risk register, as well as those described by executive leaders as being on their ‘worry lists’. The trust board had sight of the most significant risks and mitigating actions were clear.

There were plans in place for emergencies, and major incidents, the latter of which had been put into action following recent events. Plans for managing services in adverse weather, a flu outbreak, and infections requiring source isolation or a disruption to business continuity supported the continuing delivery of services.

The Finance Committee provided formal financial reports, which included information on the trust’s financial performance and position. This supported the submissions to NHSI on a quarterly basis. We noted the report for month five; August 2017/18 included the trust’s expenditure position, the Cost Improvement Programme, Capital and Working Capital Plans. Separate Cost Improvement Plans indicated detailed information by work stream, and included RAG ratings. The only red rating noted on the programme summary for September 2017 was in relation to outpatient transformation plan.

The chief financial officer told us cash flow was poor, with an impact on service delivery, such as cancellation of surgery due to non-payment of fees. The trust was currently making monthly requests for money and took careful consideration with regard to how it used financial resources. For example, the monthly Investment Board meetings allowed a full review of presented pro formas to establish the impact of having a particular role or technical device. Operations personnel presented their case and they were provided with a written outcome, good or bad.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability.

**Information management**

The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff told us they had access to all necessary information and were encouraged to challenge its reliability.

The trust was aware of its performance through the use of KPIs and other metrics. This data fed into a board assurance framework. For example, we were told by the COO information was collected through reports at operational level. However, they believed that the new dashboard would provide stronger and more dynamic data needed. This would include PRUH data, as currently this was not the case.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.
The board and senior staff expressed confidence in the quality of the data and welcomed challenge. Information was in an accessible format, timely, accurate and identified areas for improvement.

The ‘Perfect Ward’ System enabled staff to collect timely data in a way which was not over burdensome for front line staff. There was instant access to data and trends could be identified with relative ease.

There was a pharmacy medicines safety scorecard used to monitor activity (e.g. medicines incidents by site and degree of harm). This data was used to identify areas that needed more pharmacy staff intervention with the trust.

The Pharmacy department monitored the Service Level Agreements with regards to Homecare arrangements and the Outpatients Pharmacy (managed by LloydsPharmacy®) with regular KPIs and ensured effective oversight of these third party providers.

Regular medicines audits were completed, including the following audits; Controlled Drugs, missed doses, medicines safety and security, antibiotics and medication safety metrics based on NICE guidance. These ensured that the pharmacy department monitored and identified areas for improvement.

IT systems, printers and telephones were generally working well and they helped to improve the quality of care. However it was recognised there was a need to have additional mobile computer terminals in wards. Access to capital was difficult, even though it was recognised the need to replace 300 printers and 500 new PCs. Despite this, the trust was investing in systems to support electronic patient records (EPR) at PRUH. This would bring it into line with KCH. Training on the EPR was due to commence two weeks after our inspection.

Further work was in progress related to the digital pathway, with pilots taking place in a number of areas to link five different systems together. This was expected to go live in December 2017. After this paper records would not be needed. Patients would also be able to book outpatient appointments via telephone, with facilitation for a range of languages, linked to the new data regulations starting in May 2017.

The commission received some statutory notifications. During the past year, this had included a number of notices regarding diagnostic imaging, reflecting the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER. We also received statutory notes of change. However, it was notable that the commission had not received any statutory safeguarding notifications related to the application to deprive a person of their liberty or its outcome.

The trust had completed the Information Governance Toolkit assessment. An independent team had audited it and the trust had taken action where needed.

With respect to information governance, we were told new printers would have secure access, even when Wi-Fi enabled. The Information Governance Group oversaw the governance arrangements in this area, which included reviewing all incidents. An information governance workbook had been circulated to staff to ensure a consistent and safe approach.

The trust had information governance systems to support the safe and appropriate management of sensitive information, including confidentiality of patient records. However, we found there were some continuing concerns with regard to how patient records were managed during outpatient clinics at PRUH. Whilst we were assured the new electronic record would resolve the matter, in the interim the way the risks was managed did not give us sufficient assurance of the potential to breach data protection and patient confidentiality.
There had been thirty reported data security breaches in the past year. These had been investigated and learning as a result was communicated accordingly.

**Engagement**

The head of patient engagement and patient experience described some of the methods which supported a structured and systematic approach to engaging with people who use services, those close to them and their representatives. This included patient opinion via NHS choices, twitter and Facebook.

Patients, carers and visitors had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Online surveys were available for inpatient, outpatient and other areas. Inpatients were able to complete feedback cards on wards. ‘How are we doing’ cards were also available for relatives, carers, friends or visitors to complete.

Feedback with regard to patients’ experiences was collected through the Friends and Family Test. Results made available publicly suggested with respect to PRUH, 94% of the 654 respondents recommended this hospital.

With regard to Kings College Hospital site, 95% of the 1171 responses recommended this hospital.

A separate staff survey showed that out of 2059 staff responses, 84% of staff recommended the trust for care. However, only 58% of staff who completed the survey recommended the trust as a place to work.

There was good awareness of the feedback from staff and the work which was needed to raise staffs responses both in terms of numbers but also their level of satisfaction.

The tool they used for comments enabled close analysis into what patients were saying. However, it was recognised there were gaps with regard to engagement with travellers, and work needed to be done in this area, as well as addressing gaps in reaching older people, although volunteers were encouraged to help patients to complete surveys.

With regard to hard to reach populations, there was acknowledgement that demographic information was sought on the paper surveys but this needed to be further developed to enable more specific questioning.

The trust had established contact with both Bromley Dementia Action Alliance and Southwark Dementia Action Alliance. Meetings were being set up to take place in both KCH and the PRUH with dementia leads from nursing/medicine/service management to develop closer working with the Alliances as they worked towards the Dementia Charter.

We were told there was a positive relationship with Macmillan London. Two joint listening events with cancer patients had been held, one in July and in October. The feedback was being used to inform cancer care developments at King’s and also to support Macmillan’s work to re-invigorate patient communication about the recovery package.

There was good engagement with CCG, NHSE and others via the STP Executive Group. Minutes reviewed indicated a wide and varied range of topical discussion, as well as agreement of actions to be taken and progress on these.

The safeguarding team had scope to collect information in the patient experience survey. In addition they had undertaken two surveys related to children and one with parents. Questions included; how were you spoken to? Were you supported? And were your concerns answered? Comments were said to have been very positive from young people who were trauma victims.
During the core service inspection we found from our discussion with staff and review of supporting information that the wards, teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.

Trust Board go and see days gave the board members an effective insight into the workings on the front line. Records were recorded of visits to departments by executives and NEDs.

The Chief Pharmacist for the trust was the local STP ‘Subject Matter Expert’ and we found that the trust took an active part in co-hosting as a medicines optimisation lead for the local area. Currently there were six work streams the trust was involved with; aseptics, procurement, clinical productivity, digital, workforce and primary care.

The pharmacy team engaged with patients through several ways. For example, in certain areas such as renal transplantation they phoned patients during active treatment to ensure that they adhered to their medicines.

The pharmacy team engaged with the rest of the trust through several methods. For example, they publish regular medicines bulletins based on medicines safety incident themes identified. Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Electronic @King’s provided detailed information to readers with regard to news, research, and governors amongst other areas.

The public board meeting was accessible, with meeting dates advertised. On the two occasions we attended the board the chair did not invite questions from the public, although it was not known if any were in attendance. Board reports were accessible on the trusts internet.

There was variation in staff perceptions regarding engagement, and acknowledgement from the NED that although progress had been made, there was still work to be done in this area.

We found there had been considered engagement with staff from senior level downwards related to the restructuring. This was felt to be an essential element of developing ownership, and whilst it delayed the implementation, the positives of this resulted in having the right people for the roles.

However, in our discussion with representatives from staff side they reported feeling not having been engaged with. They described the engagement with the “how are we doing” project? Arising from this were work streams, which would be formed to look at particular areas. Staff told us they were asked to put forward a list of people to be involved, which they did. The meetings were started without the representatives from staff side being invited. After considerable effort they had started to be invited to the meetings, although a number of these had already been held without their participation, and they felt it had become a ‘tick box’ exercise.

Staff side also reported to us that the nurses in general did not feel the management were engaged, although no evidence to substantiate this was presented.

The ‘Staff Survey Engagement Plan’, dated 15th May 2017, outlined the key actions to be taken for a number of specified themes, for example related to; diversity and inclusion, career development, senior leadership communications, relationships and visibility, and valuing and recognising staff. Responsible executive leads were assigned to each work stream and the expected measurable changes that would indicate progress.

The safeguarding leadership team had surveyed staff about how they were doing in relation to safeguarding. As a result of the responses action was taken to improve some aspects of the service. This included the provision of safeguarding nurses in the emergency department 24 hours a day and out of hours.
The director of medical education oversaw the medical and undergraduate training over both main hospital sites. They had protected time to speak to the junior doctors about issues related to their training and development. They reported to us the main issues at present related the new junior doctor contract, which had led to a significant degree of low morale. They were doing their best to ensure the doctors felt supported, and they spent time at both hospitals. They had developed ‘Kings improvement through engagement’ (KITE). This provided opportunities for nurturing engagement with the junior doctors who then asked more questions, which led to quality improvement.

Junior doctors who spoke with us in focus groups provided a range of comments, including; “it’s the best year of training so far”, and there had been “well planned rotas”. Consultants were described as “easily available, and often just a phone call away”. We were told there was a “huge amount of opportunity”, and a lot of thought went into the training rota, although the teaching ability was very variable. A doctor who had joined the King’s team more recently told us they had a lot of protected study days, and when they went on the on call rota they had a shadowing opportunity and were doubled up for the first six months.

In response to the staff survey an action plan had been put in place. We noted from our review of this that with regard to training and career progression, a stakeholder group was formed prior to commencement of the associated work stream. This had been used to shape the content of the career conversations tool, which had been designed and signed off by Nursing Board. Human resource business partners were briefed and face to face meetings took place with heads of nursing on both sites to agree the roll-out plan for their areas, which commenced in August 2017, supported by conversations skills workshops for line managers.

The COO told us they met on regular occasions with other local providers and partners, neighbouring trusts, CCGs, patients and governors. However, we found there was poor interaction between staff side and the COO, as the conduit to the Board.

The trust provided the opportunity for people to sign up to the King’s membership, which was made up of local people, patients and staff. Membership provided an opportunity to say how the local hospital was run. Additional benefits were linked to membership, such as; access to ‘Members Health Talks’, up to date information through the @King’s on-line communication. Members could vote for governors, participate in community events and have their say.

There were opportunities for voluntary and community organisations to join the trust as an Associate Member. This had been launched a month prior to our inspection and 30 groups had already joined this.

A member of the executive team told how proud they were of the work done in outpatients. A patient story had indicated they experienced long delays in getting through to switchboard at the PRUH. Improvements had been made, resulting in an average wait of 12 seconds at PRUH and 17 seconds at Denmark Hill for the call response. Targets were set at 30 seconds.

The head of patient engagement and patient experience told us how proud they were of the King’s membership and the level of engagement. They described the relationships with local Healthwatch as positive, with regular enter and view visits in the previous year. In addition, Healthwatch was looking at the older people’s pathway in ED. The team were working with Macmillan to hold a listening event as a means of gathering further patient experience information.

The trust had approximately 700 volunteers who were enthusiastic and committed. Two new projects were in progress, including a volunteer service in ED and hand massage for end of life patients.
The trust offered Governors (in foundation trusts), training on appointment. They were actively involved in the operation of the trust.

Patients, staff and carers were able to meet with members of the trust’s leadership team and governors to give feedback. We noted however, the head of patient engagement and patient experience did not have specific contact with the patient governors.

The chief financial officer spoke to us about their role in chairing an elderly care forum for PRUH and the referring GP.

Division leaders, on behalf of front line staff, engaged with external stakeholders such as clinical commissioners and Healthwatch. Minutes of commissioner meetings indicated discussion and consideration of various matters including for example; performance, activity plans, RTT, and the Commissioning for Quality and Innovation (CQUIN). Actions were identified with responsible individuals noted.

The King’s College Hospital Clinical Quality Review Group minutes indicated proactive engagement between representatives from the main CCGs of Bromley, Lambeth and Southwark, along with NHSE and respective staff from the trust.

The divisional leads told us there was a “great relationship” with Bromley CCG. They were described as very supportive. There was a plan in place with the partners but it was not as yet at a much better than the previous year. They recognised the need to run the ambulatory care service until 10 pm instead of 5 pm. It was also acknowledged there was a need to create more services that would treat people to get them home sooner.

Divisional leads sat on the emergency department delivery board in Bromley and Lambeth.

The local CCGs were represented on the Drugs and Therapeutics committee (DTC). NEDs told us they did one version of the truth with the CCG, and there was huge willingness by the CCGs to look at whole system across the piece. The need now was to get into a room to have a candid discussion.

KCHFT Acute Finance & Information Group held meetings with the CCGs and NHSE. We noted from minutes reviewed there was discussion around performance, contracts, indicative activity plans, CQUIN reserves, as well as specific issue from the CCG and NHSE perspective. Actions were agreed as relevant.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans (STP). A weekly meeting was held with the chief financial officer and partners in which the modelling and capacity for example was discussed.

The trust encouraged students from Lambeth College to be volunteers and to take part in Partnership Challenges as part of a programme of work with local businesses and organisations.

**Learning, continuous improvement and innovation**

The executive lead for transformation and ICT had been in post for a year and was responsible for leading on the change programme, linked to digital progress.

There were organisational systems to support improvement and innovation work. Since the last inspection in 2016 the King’s academy had been launched and a number of staff had been trained in quality improvement.

Staff were encouraged to make suggestions for improvement and had given examples of ideas which had been implemented so far. There were 12 areas identified as needing to improve. These
related to aspects of service that most concerned people. For example; theatres not starting on
time, the emergency department, the bariatric pathway, and access and flow of patients.

Staff were consulted on with respect to waves two, three and four, giving feedback on their
concerns or worries. Wave four was said to include the pathway for neurology patients, reviewing
access for specialty and sequencing of diagnostics.

Improvements had already been seen as a result of this focus. For example, we were informed
waiting times for some services had decreased. This included, pancreatic cancers, diagnostic
pathways. The new bariatric pathway was due to be launched this month. The pathway was
previously two-three years but has been designed to enable the patient to see all relevant
clinicians on the same day, with a multidisciplinary meeting held afterwards.

We were told there had been a high level of focus on systems and processes. The ‘Perfect Ward’
had enabled more than 3000 inspections to be completed, with instant reporting on results and
these were a driver for improvements.

The trust had a ward accreditation scheme, ‘The King’s way,’ which provided a single
standardised approach looking at everything from how linen was stored to aspects of patient care.
Every process on the ward had a standard operating procedure. The aspiration was that it would
be multi-professional but was only in nursing at the time, although they were making progress on
this.

On the medical wards they had a medical lead and the specialist had been brought to the table
and signed up to it. A patient ‘bed board meeting’ with all professionals took place daily followed
by a patient round, which was standardising best practice.

Front line staff attended the Quality Assurance Research Committee (QARC) and talked about
what was going well and not so well. This provided them with an opportunity for a healthy degree
of challenge and scrutiny, as well of assisting in identifying resolutions.

We found that staff had learned from medicines related safety incidents and could demonstrate
action taken as a result. For example, due to a shortage of a particular medicine (enoxaparin), the
trust had to change their formulary to an effective alternative heparin medicine. This involved
further training and learning. Staff were made aware of the changes in various ways, for example
via a medicines safety bulletin around the ‘Change in Heparin’ that had been circulated earlier in
the year from the pharmacy team.

The trust actively sought to participate in national improvement and innovation projects. The
pharmacy department told us about an innovative service involving placing their specialists in GP
practices to look at long terms conditions that the trust specialised in. The aim of the project was
to lower the rate of avoidable admissions to the trust. In addition the department was currently
working with NHS digital (a STP work stream) to look at improving the electronic prescribing
process for medicines optimisation. Finally, the pharmacy department informed us that they had
several publications related to medicines safety, including winning a HSJ® award.

The trust had a planned approach to take part in national audits and accreditation schemes and
shared learning.

The trust was actively participating in clinical research studies. As a founding member of King’s
Health Partners (KHP) the Trust had a partnership that brought together world-class research,
education and clinical practice with the single aim of improving the entire patient experience. KHP
was said to be working together to form a number of globally competitive clinical academic
institutes. These institutes would support the continued delivery of excellent care, as well as strengthen London as an international centre for clinical academic excellence.

During 2016/17 more than 13,000 patients were involved in any one of the 500 plus research studies, which included specialised areas and studies directly related to increasing the understanding of mental health issues.

A culture of research was said to be integrated in that was done at the trust. Each clinical area had research meetings. We reviewed examples of research and innovation newsletters as well as evidence of research drop in sessions. Two major areas of research mentioned to us related to trauma and critical care, in addition to numerous speciality studies in the various clinical areas.

We were told in our discussion with the heads of clinical audit and research they were “very proud to have fostered and developed a lot of people in the research area”. As well as developing staff the knock on effect had been to the “benefit of patients and families.”

We reviewed a number of learning from deaths investigations and found there was a comprehensive and systematic process for doing so, which involved a range of professionals. Mortality minutes recorded at the Mortality and Morbidity Committees were available through the divisions. Patient outcomes reports were generated and learning arising from the review was shared with staff, and contributed to improvements. Family, where relevant were involved, and duty of candour was applied as necessary.

Staff used quality outcome data to drive improvement. The use of the ‘Perfect Ward’ enabled regular recording and rapid access to data. Such information was discussed within the various committee meetings, at team meetings and within board meetings.

Performance data and incident reports were also used to monitor staff adherence to protocol and where evidence indicated this was not being fully achieved, actions were taken. This included by way of example, the use of ‘pause for gauze’ in operating theatres, as a result of an adverse incident related to needle counts during a surgical procedure.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. For example, following issues related to the training environment in radiology, the team carried out a look back exercise, where they considered if there had been any triggers and what needed to be done to improve before implementing the changes.

With regard to pharmacy provision there had not been any front of shop team in ED. This had now been addressed, and as a result improvements had been seen to medicines reconciliation, along with quick drug advice provision to the clinical team and an improved discharge medicines process.

Work was in progress to improve opportunities to gather patient feedback data. This included easy read material for children and the development of an information technology application for engaging with children. The development of an easy read feedback system for learning disabilities was nearly at pilot stage.

King's Commendations recognised those individuals who made outstanding contributions to patient care or hospital services. These were linked to the values of the trust. People who were awarded a commendation received a certificate and silver gilt lapel badge; teams receive a framed certificate presented by the Chairman of the Council of Governors.

The trust had been working with NHSE regarding children and young people with learning disabilities and autism to improve the theatre journey. They were incorporating this into the pre assessment work.
External organisations had recognised the trust’s improvement work. Individual staff and teams received awards for improvements made and shared learning. For example, radiographers had received ‘team of the year’ during the weeks immediately prior to our inspection. A kindness award from Lambeth CCG for kindness to Grenfell tower patients had been presented to volunteers.

## Acute services – King’s College Hospital

### Medical care (including older people’s care)

<table>
<thead>
<tr>
<th>Facts and data about this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medical care service at King’s College Hospital provides care and treatment for general medical services and specialist services including renal, liver, haematology, cardiology and stroke services, as well as care of the elderly services.</td>
</tr>
<tr>
<td>There are 419 medical inpatient beds and two day-case beds located across 20 wards. The trust had 84,246 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 28,831 (34%), 6,187 (7%) were elective and the remaining 49,228 (59%) were day cases. Admissions for the top three medical specialties were:</td>
</tr>
<tr>
<td>• General Medicine – 30,883 admissions</td>
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<tr>
<td>• Clinical Haematology – 17,619 admissions</td>
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<tr>
<td>• Cardiology – 6,054 admissions</td>
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</tbody>
</table>

We visited 15 medical and specialist medical wards: the cardiac catheter laboratory, endoscopy unit and the discharge lounge. The wards we visited included:

Charles Polkey (neurology)
Lawrence Ward (acute medical unit)
Marjory Warren Ward (health and aging)
Longsdale (respiratory)
Donne Ward (health and aging)
Annie Zunz (acute medical unit)
Byron (health and aging)
Davidson Ward (haematology)
Friends Stroke Unit,
Mary Rae Ward (diabetes/endocrine)
Matthew Whiting (acute medical unit)
Elf and Libra Ward (haematology)
Waddington Ward (haematology)
Derek Mitchell (haematology)
Oliver Ward (General medical, respiratory, gastroenterology and sexual health).
During our inspection, we spoke with 75 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team, 18 patients and five relatives. We reviewed 5 patient records on the electronic record system and a number of bedside patient notes, some electronic prescription charts online and many pieces of equipment.

**Is the service safe?**

**Incidents**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between 01 July 2016 and 30 June 2017, the trust reported two incidents classified as never events for Medicine.

- **Source: NHS Improvement - STEIS (01/07/2016 - 30/06/2017)**

In accordance with the Serious Incident Framework 2015, the trust reported 35 serious incidents (SIs) in Medicine, which met the reporting criteria set by NHS England between 1 July 2016 and 30 June 2017.

Of these, the most common type of incident reported was:

- Slips/trips/falls meeting SI criteria with 12 (34% of total incidents).
- Treatment delay meeting SI criteria with seven (20% of total incidents).
- Pressure ulcer meeting SI criteria with seven (20% of total incidents).
- All other categories with four (11% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (9% of total incidents).
- Unauthorised absence meeting SI criteria with two (6% of total incidents).

We reviewed the root cause analysis for two of the medical services serious incidents and found appropriate investigations had taken place. We found the trust had analysed the contributing factors to the incident and identified actions to reduce the risk of similar incidents occurring in the future. For example, an incident occurred in which a patient left one of the medical wards. To improve management of patients subject to sectioning under the mental health act the trust had
reviewed the handover process, supervision of the patient, training for staff and opened up advertising of shifts for registered mental health nurses to agency as well as bank.

Staff continued to use an electronic computer incident reporting system, which could be accessed on the hospitals computers. Staff were aware of how to report incidents and could show us how to access the online system.

Staff told us they were encouraged to report incidents and the incident reporting culture was still good within the hospital. Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.

Staff feedback following incidents was good. Staff received regular feedback and learning points from incidents, including those that occurred in other units within the hospital. Learning was shared via a range of methods including directly through email mail outs and at staff meetings.

Staff were able to describe action points from incidents. For example, staff on the health and aging wards told us there had been a number of incidents around patient falls. The service had delivered training on patient, slips, trips and falls for staff. Falls stickers were added to the patient flow board and staff were made aware of patients at risk during handover. If a patient was at an increased risk of falling they would be allocated a staff member who would sit with the patient during the shift. This was called ‘specialing’.

Following a serious incident on Oliver Ward, the trust had closed the ward for two weeks in order to protect patient’s safety. Staff were able to describe the actions the trust had taken to make improvements including staff training and improving leadership on the ward.

There were formal arrangements to review mortality and morbidity (M&M) and learning from such reviews contributed to improving patient care.

The duty of candour (DoC) is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.

**Safety thermometer**

The Safety Thermometer is used by trusts to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harm and their elimination.

We were informed that this method of collecting patient safety related data was no longer used at the trust. In its place, staff were using the ‘Perfect Wards’ system. This was a weekly audit looking at a range of indicators such as infection, prevention and control; staffing; falls and pressure ulcers. This could be completed on a hand held computer device by each ward and provided the trust with up to date and live data of their performance.

We reviewed pressure ulcer information from April 2016 to March 2017, which showed there were some hospital acquired pressure ulcers on medical units. We also reviewed falls data from July
2017 and medical wards with the highest number of falls were Oliver Ward (eight falls) and Donne Ward (six falls).

Venous Thromboembolism (VTE) risk assessments were recorded on the patients’ records. The trust audited completion of VTE risk assessments to ensure they were being completed on admission. We reviewed VTE audit data between September and July 2017 for the medical wards we visited during the inspection. Compliance was between 90% and 95%.

Cleanliness, infection control and hygiene

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids.

All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

There were housekeeping staff for cleaning wards and specialist medical units and cleaning staff understood cleaning frequency and standards.

Throughout our visit we found the wards and specialist medical units were visibly clean, tidy and free from dust.

We reviewed patient areas across the wards as well as dirty utility areas and treatment rooms. All areas were visibly clean. Patients and relatives were satisfied with the level of cleanliness on the wards.

Green ‘I am clean’ stickers were used to identify which equipment had been cleaned by staff and were ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned and observed staff replacing stickers once they returned the clean equipment.

We inspected various items of equipment, including patient commodes. We found a good level of cleanliness including under the seats and on the commode legs.

Infection prevention and control (IPC) was part of mandatory training and had been completed by 75% of staff. This was below the trust’s target of 85%.

There was easy access to personal protective equipment (PPE). Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to handwashing and drying facilities. Services displayed signage prompting people to wash their hands and have guidance on good hand washing practice.

On Davidson and Elf and Libra Wards (haematology) staff asked visitors to wash their hands before entering the ward. We observed the ward clerk asked all visitors who entered the wards to wash their hands including staff members, relatives and our inspectors. Staff told us they would prevent people from entering the wards until they washed their hands.

Staff were ‘bare below the elbow’ and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.

Where patients had a known or suspected infection, they were nursed in single rooms. There were signs displaying presence of infection, which meant staff, and visitors were aware of the
precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed to these areas. We saw there were leaflets available for patients about infection control and isolation. These provided details about the purpose of isolation and what was required.

On some wards there were only two bedded bays available to use for isolation of patients. This created an issue when patients needed to be isolated as it required the blocking of a second bed.

During the inspection Mary Rae Ward was on enhanced infection and prevention control caution due to an outbreak of Carbapenemase-Producing Enterobacteriaceae (CPE). Enterobacteriaceae are a family of bacteria, many of which live naturally in the bowels. These bacteria produce carbapenemase enzymes that can break down many types of antibiotics, making the bacteria very resistant. We observed good infection, prevention and control on this ward. Staff and visitors were required to wear personal protection equipment (PPE), including gloves and aprons upon entering the ward. Patients who had tested positive for CPE were isolated appropriately, minimising risk to other patients.

We observed bed space curtains were labelled and dated when they were last changed.

The trust conducted monthly infection prevention and control audits including hand hygiene audits across medical wards. We reviewed audit data and saw performance varied across wards. On Byron Ward compliance with hand hygiene for doctors was 50% in February 2017. However, between March and June 2017 this had improved to 100%. In May 2017 Marjorie Warren Ward had an overall poor performance of 46% compliance with hand hygiene. By June this had improved to 100%.

Waste management, including those for contaminated and hazardous waste was in line with national standards.

In endoscopy, staff maintained decontamination standards in line with national best practice such as guidance from the Medicines and Healthcare Products Regulatory Agency. However, the decontamination room was not directly linked to the clinical area and staff had to walk past the pharmacy store in order to access the decontamination room, which posed an infection risk.

Environment and equipment

There were reception desks on all wards, which were staffed by ward clerks. This meant visitors had a point of contact on admission to the ward Monday to Friday.

There were rooms available to relatives on some of the wards we visited, such as Davidson Ward and Elf and Libra Ward. We saw information leaflets and magazines, and on Elf and Libra Ward, we saw games and toys for children and young people available in the rooms.

Patients had access to showers and bathrooms and these were accessible for disabled patients. At the last inspection, the endoscopy suite area was prone to flooding following heavy rain. We found maintenance had resolved this problem and flood kits were available for staff and maintenance could be called if there was an emergency.

Staff told us there was sufficient access to equipment to meet the needs of patients receiving care. Any equipment required was provided in a timely manner. The trust maintained a log for equipment that required repair.
The trust maintained an inventory of equipment and service schedules as per recommended guidance. The service schedule guideline is derived using a scheme described by the London Hospital Clinical Engineering Benchmarking Group. This set out the recommended minimum frequencies for service by taking into consideration both manufacturer recommendations and the risk posed by failure to maintain the equipment.

Needle sharp bins were available throughout medical wards and within the medication preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.

Staff told us they were able to access equipment required to care for patients and access to computer terminals to allow access to pathology and imaging results for example as well as policies and guidelines.

During our inspection, we checked various items of equipment across medical and specialist medical wards and the majority of equipment displayed in date safety checks. However, we found two blood pressure machines on Annie Zunz Ward which had not been recently tested. When we asked senior staff to show us the equipment checks log, they were unable to provide us with this. Therefore staff could not be assured the calibration was accurate.

We observed spare consumables and other equipment were appropriately stored and labelled. We checked various consumables, such as fluids, and found most of them were in date. Some out of date items were identified and these were disposed of by ward staff when highlighted by the inspection team. We were not always assured staff were checking dates of consumables.

When we inspected Davidson Ward, there was an issue with the door access to the treatment room. We saw staff appropriately escalated this to the facilities team and the issue was resolved quickly to allow staff access.

Resuscitation trolleys were available at appropriate intervals throughout the medical ward and endoscopy. Trolleys were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Trolleys were usually checked daily with staff signing to confirm the checks had been made. We reviewed a number of ward’s record checks and found some gaps in documentation. For example, on Davidson Ward and Lonsdale Ward, there were significant gaps in checks between June 2017 and August 2017. If checks are not completed on a daily basis it could mean equipment is out of date or might not work properly if required for use. This posed a risk for patients.

On RD Lawrence Ward and Annie Zunz Ward there were no single bay isolation rooms. This meant when a patient was an infection risk they needed to be isolated in a double bay room. The second bed was then out of use and reduced the services capacity. When we met with senior leaders, they highlighted this as being one of the risks within the service.

**Medicines**

There were systems in place to ensure the safe supply and administration of medicines in accordance with NICE NG5 Medicines optimisation: the safe and effective use of medicines.

Medication management was part of mandatory training. Compliance was below the trust target of 80%. We requested for more up to date mandatory training information but this was not provided.
Electronic medical administration records were used across the medical and specialist medical wards. Staff were required to be logged on to the system when administering medicines. This system facilitated communication between the pharmacy and ward staff, which improved patient flow, such as preparation of medicines for discharge.

As we previously found, there remained good access to pharmacist support and pharmacists were part of the daily ward rounds. Pharmacists still helped with the checking of prescriptions charts and identifying any issues.

We saw the unit used a medicines reconciliation process, which meant that when patients were admitted to hospital the medicines they were prescribed on admission corresponded to those they were taking before admission.

We observed staff on each unit preparing and administering intravenous and oral medicines. They followed correct procedures, including checking the dosage, the expiry dates, patient identification and any allergies.

Nursing staff were aware of the policies on the administration of controlled drugs. Controlled drugs (CD), which are medicines requiring additional security, were stored in lockable, wall-mounted cupboards. On each unit, the keys for these cupboards were held by an allocated nurse, which was in line with trust policy.

Registers containing details of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked the CD stock levels collaboratively on a daily basis. During our inspection, the CD stock levels documented in the stock books were checked and were accurate.

Medicines to take out (TTOs) were on the ward before patients were discharged and were stored securely until the patient was discharged.

We saw medicines were stored in dedicated medicine fridges when needed; these were locked and the fridge temperature recorded. Checks of temperatures were recorded daily and fridge temperatures were recommended to be between two and eight degrees Celsius.

When we reviewed records on Davidson Ward, we found staff were not doing daily checks for one of the fridges in the treatment room. We raised this to the ward manager who informed us they were aware of this issue and had recently introduced a ‘Nurse in Charge Checklist’. Each day the nurse in charge was required to check various things on the shift, including whether the fridge temperature and been checked. This had only recently been started by the new ward manager.

On Annie Zunz Ward, we reviewed the fridge temperature records and saw the highest recorded temperature had exceeded eight degrees Celsius a number of times. In August, there was a period where the temperature had reached between 10 and 15 degrees Celsius. For the week during our inspection, the fridge had reached up to 14 degrees Celsius. Staff told us they had reset the fridge each time it exceeded the temperature limit. However, staff were not able to tell us the escalation procedure for reporting this. We raised this concern with the matron, who then informed us that facilities had been informed of the issue with the fridge. We asked if pharmacy had been informed, as the fridge contained medications that were required to be stored at certain temperatures. The matron informed us that pharmacy had been contacted but there had been no discussion with pharmacy about the use of the items in the fridge. We were told they would be chasing this up with them.
We checked the expiry dates of a number of medications across medical wards. We found some medications were out of date. For example, on RD Lawrence Ward we found one drug, which had expired at the end of August and was still in the drug cupboard.

**Records**

The trust was still using an electronic patient record (EPR) system. Each profession involved in the care of a patient recorded information in chronological order in the clinical notes system. This included a section for the medical plan of the patient.

Nurses used paper documentation to record a range of risk assessments and care plans for patients. We found the completion of these documents was good throughout medical services. We saw evidence of falls, pressure ulcer and nutritional risk assessments with appropriate care plans in place to manage the risks.

We reviewed five records on the EPR and found good levels of completion. There was evidence patients were seen on post take ward rounds within 12 hours of admission and Venous Thromboembolism (VTE) assessments were completed.

Information Governance training was part of the mandatory training which all staff were required to attend. The trust target was 80% of staff having completed the training. Data provided by the trust indicated that 57% of staff had completed this training which was below the trust target.

We saw three occasions where computers were logged into patient records and left unattended. This was a risk because other unauthorised people may have been able to access confidential patient records on the computer.

When we entered RD Lawrence Ward, we saw nurse handover information had been left on the reception desk. This included some confidential patient information such as name and diagnosis. This was a risk because visitors could have accessed confidential patient information.

Agency staff could not access the EPR, which limited their access to patient’s clinical notes. Agency staff were also unable to add clinical notes to a patient’s record and completed their parts within the bedside nursing notes. We were not assured that the hand written notes were added to the patient’s electronic record. As a result the EPR was not always contemporaneous and may not have contained information specific to the treatment or care provided by the member of agency staff.

**Safeguarding**

The arrangements around safeguarding vulnerable people had not changed since our previous inspection. Staff had access to the trusts safeguarding policy and knew how to access the safeguarding team for advice and guidance when required. Staff told us the team were supportive in giving advice and guidance where required.

Safeguarding information, including contact numbers and the trust lead were kept on wards and staff were aware of how to access this.
Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and were able to define triggers that would prompt them to obtain a safeguarding assessment for patients.

Safeguarding adults and children training was completed by staff as part of the trust's mandatory training schedule. All staff were required to attend this training. The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for King’s College Hospital is shown below:

<table>
<thead>
<tr>
<th>Course</th>
<th>Percentage completed</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult 1</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adult 2-5</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children 1</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children 2</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children 3</td>
<td>64%</td>
<td></td>
</tr>
</tbody>
</table>

Two of five courses had surpassed the 80% threshold, which were in excess of 90%. The other three courses were below the 80% target by 14% - 18%. This may be reflective of a longer course syllabus specific to this module, meaning training staff was lower and had a higher impact on day to day business. These results could also indicate these courses were not mandatory for day to day operations, or possibly required specialist instructors.

**Mandatory training**

Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Ongoing mandatory training was undertaken as e-learning modules and further classroom based sessions.

The trust had recently changed its provider for the monitoring of mandatory training with the hope that this would improve recording attendance and completion rates. Ward managers said they hoped this would improve how they monitored mandatory training on their wards.

The trust set a target of 80% for completion of mandatory training.

A breakdown of compliance for mandatory courses between June 2016 and May 2017 for the
A number of mandatory trainings were below the trust target of 80% with the worst performers being Medicines Management (3%), Prevent Awareness (27%), Slips, Trips and Falls (42%) and Consent (45%).
Assessing and responding to patient risk

In line with NICE guidance, the National Early Warning Score (NEWS) was still used across the medical services to identify patients at risk of deterioration. There was also an escalation protocol to the patient's medical team or the iMobile service within the hospital.

iMobile provided critical care outreach services and were available 24 hours a day, seven days a week. The service provided by the team was reported by staff to remain good. The team consisted of a specialist registrar and nurses with good critical care experience. During office hours, the team also had access to a critical care consultant between 8am and 6pm. We saw posters and contact details of the team throughout medical wards and staff could tell us why and how they would access this service.

Patient records we reviewed showed patient observations were completed at appropriate intervals and patient care was escalated correctly.

There were some positive changes in assessing and responding to patient patients at risk of deterioration since our previous inspection. We previously identified an inconsistent approach to escalation of patients in medical services. However, during this inspection we found staff knew when and how to escalate patients. NEWS scores were discussed in handovers and any concerns were escalated to the nurse in charge.

Previously, there was no formal approach to identifying the possibility of sepsis nor was there implementation of ‘Sepsis Six’ in the medical assessment centre and acute medicine unit. The trust had taken steps to improve the implementation of sepsis bundles for patients diagnosed with sepsis. There had been education events for staff which were well attended and the iMobile outreach service had a ‘link’ sepsis nurse who supported education for both nursing and medical staff. As a result, there was now a systematic process in place for identifying and managing patients with sepsis across medical wards.

On Annie Zunz Ward, there was a sepsis bundle box available for staff. This prompted staff on the ‘Sepsis Six’ and what steps they needed to take for suspected sepsis. There were sepsis bundle packs which contained items like blood culture bottles readily available for staff to use to speed up response times.

Patients were risk assessed in key safety areas using nationally validated tools. For example, we saw risk of falls was assessed and the risk of pressure ulcer was assessed using a recognised tool known as the ‘Waterlow Score’. We saw where risks were identified appropriate care plans were put in place. For example, if a patient was at a risk of falls, nursing staff would be on increased observations with that patient. Following a number of falls within the hospital, the trust were now using ‘specials’. These were additional staff that could be arranged to sit, observe and interact with patients who were at increased risk of falls.

We reviewed training figures for resuscitation training for medical wards. Basic life support (BLS) training was below the trust target of 80% on Donne ward (79%); Oliver ward (76%), Lonsdale ward (76%) and Matthew Whiting ward (63%).

The number of registered nurses with Intermediate Life Support (ILS) training was below the trust target of 80% on Byron Ward (41%), Donne ward (0%), Oliver ward (61%), Lonsdale ward (78%), Matthew Whiting Ward (24%), Mary Ray ward (38%), Majorie Warren (47%) and Annie Zunz Ward (23%).
Nursing staffing

Kings College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fell below the trust’s target for a WTE staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
</tr>
</tbody>
</table>

As of May 2017, King’s College Hospital reported a vacancy rate of 23% for qualified nursing and midwifery staff. This was higher than the trust’s target vacancy rate of 8%.

As of June 2016 to May 2017, King’s College Hospital reported a turnover rate of 16.8% for qualified nursing and midwifery staff. This was lower than the trust’s target turnover rate of 20%.

As of June 2016 and May 2017, King’s College Hospital reported a sickness rate of 3% for qualified nursing and midwifery staff. This was the same as the trust’s target sickness rate of 3%.

We reviewed staffing vacancy rates for some medical wards and saw the biggest vacancies were band six nurses. A number of wards had a vacancy rate higher than the trust target of 8% including Oliver Ward (18%), Mary Rae Ward (17%), Marjory Warren Ward (18%), Annie Zunz (11%) and Byron Ward (14%). Longsdale Ward had an overall vacancy rate of 21%, and had a band six vacancy rate of 60%.

Senior leaders told us there was a lot of work going on to skill up band five nurses so they could progress into band six posts. This was a good developmental opportunity for nurses.

Every month wards submitted a patient dependency report. This was based on the Safer Care Nursing Tool Kit SCNT. The SCNT is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. This data was used in conjunction with Nurse Sensitive Indicators and professional judgement to set the nursing establishments within a ward area.

The trust had installed noticeboards on every ward which show planned and actual staffing levels on a shift by shift basis. These were updated daily. During the inspection we saw the majority of wards were staffed according to planned staffing levels. Staffing levels were also formally reported to the trust board and the public.

Information provided by the trust indicated planned and actual staffing levels for registered nurses and healthcare assistants. We noted from the information there were numerous times where staffing exceeded the planned levels. Justification for this was indicated, such as a patient needing one to one support.
A RAG (red-amber-green) rating approach was used daily to assess the safety of staffing levels and used to inform escalation to the duty matron. Senior leaders told us the aim was to ensure all shifts were staffed to green, even if this meant having to use agency staff.

Data provided by the trust indicated they had concerns about staffing levels on Oliver Ward and Mary Ray Ward. When we spoke to staff on these wards, they identified staffing issues but said it still felt safe. Staff were also kept up to date from senior leaders regarding what actions the trust were taking to improve staffing levels.

The trust were doing a significant amount of work on recruitment in order to increase staffing levels. At the time of our inspection, one of the practice development nurses from the health and aging services was abroad on a recruitment drive for the trust. The neurology ward had developed a video for recruitment days of new staff in order to sell the service to graduates.

Staff told us managers were responsive when they had concerns about staffing levels. On Oliver Ward staff told us that previously when they raised concerns, they were ignored. However, since the new leadership team had come in, any issues raised regarding staffing numbers were responded to.

Healthcare assistants (HCA) were specifically trained as ‘specials’ to support patients who had complex needs. During the inspection we observed specials sitting with patients to ensure they were safe. On one ward a patient who was at risk of falls was being ‘specialed’ to ensure they did not fall out of bed or fall when walking.

On Donne Ward, there was a ‘nurse associate trainee’ role. This was where a band two or three HCAs was being trained to be a nurse associate. On completion of this, the HCA would become a band four. This meant there was progression for HCAs within the trust.

We observed two handovers during our inspection on Annie Zunz Ward and Oliver Ward. We observed a well-structured and detailed handover in which all key information regarding patients was discussed. This included: NEWS scores, resuscitation status and treatment plans for the day, including any scans or tests.

Vacant shifts were filled by bank and agency staff to ensure wards were safely staffed. Mary Rae (between 14% and 15%) and Oliver Ward (between 8% and 17%) had the highest use of agency staff between May and August 2017. All new bank and agency staff were orientated and inducted on to the ward they were required to work.

**Medical staffing**

The trust reported their staffing numbers below for the period June 2016 to May 2017. These numbers fell below the trust’s target for a whole time equivalent (WTE) staffing level of 2183.09 within the medical staffing arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>1885.88</td>
<td>2090</td>
</tr>
</tbody>
</table>
As of June 2016 and May 2017, King's College Hospital reported a vacancy rate of 14.5%. This was higher than the trust’s target vacancy rate of 8%.

As of June 2016 through to May 2017, the King’s College Hospital reported an average turnover rate of 3.5% in the medical and dental arena. This was notably lower than the trusts target turnover rate of 20%. Of note, there was a spike in the monthly turnover rate in August 2016, when it was recorded as 14%.

As of June 2016 through to May 2017, the King’s College Hospital reported an average sickness rate of 2.6% in the medical and dental arena. This was below the trust’s target sickness rate of 3%. The monthly rate exceeded 3% from January – March 2017.

Between 1 April 2017 and 30 April 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 511 whole time equivalent staff working in Medicine at King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Senior leaders told us that there were still enough junior doctors to fill the medical roster. There were weekly meetings held to review the junior doctor rota and ongoing rolling recruitment for gaps.

We reviewed locum fill rates for some of the medical wards. We saw Matthew Whiting Ward had an average fill rate of 46% between March and August 2017, which was high.

We spoke to some junior doctors who said they felt supported from senior medical staff. There was a consultant trained in general or acute medicine on call at all times and they were able to reach the unit within 30 minutes. There was also access to specialist consultants if required via an on call system.

Senior leaders told us they wanted to align some of the junior doctor posts to particular specialities and interests, such as respiratory care.

We observed a board round and ward round and saw they were still carried out efficiently and effectively, with appropriate staff present.

Major incident awareness and training
In the event of a major incident the hospital allocated gold and silver commanders who would communicate regularly through ‘Major Incident/Business Continuity Incident Control Team Meetings’. This provided the hospital with a single point of coordination.

Staff still had a good understanding of the trusts major incident procedure and could show us how to access this on the trust intranet page. We reviewed the major incident policy, which was in date and gave guidance for particular ward areas. Staff had access to action cards, serving as prompts to guide them on what to do in the event of a major incident.

Major incident and emergency planning was part of the junior and middle grade doctors’ induction programme.

There had been three major incidents in London in the 12 months preceding our inspection, which King’s College staff had responded too. Feedback from staff was very positive about how the services and the trust had responded to the incidents. Following the London attacks staff were provided with psychosocial care guide which provided information on how to access support.

Is the service effective?

Evidence-based care and treatment

Following the recent trust divisional restructuring, a ‘Patient Outcomes Lead’ post was created in each Care Group. Patient Outcomes Leads were responsible for ensuring the implementation of NICE guidance within the Care Group. As a new role, this was still under development.

Practice development nurses (PDNs) and clinical nurse specialists (CNS) played a role in ensuring staff were up to date with any changes or new national guidance.

Clinical guidelines were in place to guide patient care and treatment for specific procedures and interventions. We saw evidence that clinical guidelines were written in line with current best practice and referenced national standards. For example, the protocol for responding to acutely unwell patients.

Policies and procedures were available on the trusts intranet page and staff were able to show us how to access them.

Patients on acute medical units were seen by a consultant twice per day in line with best practice guidance.

Joint Advisory Group (JAG) accreditation is a formal recognition that an endoscopy service is fully competent to deliver against specific measures, as identified by the ‘Global Rating Scale (GRS)’ standards. The endoscopy unit had JAG accreditation.

The endoscopy service followed an integrated care pathway, which incorporated the World Health Organisation (WHO) surgical checklist and followed National Standards for Invasive Procedures.

The trust had introduced the perfect ward initiative to help improve quality of care on medical wards. Perfect ward helped staff to have a clear view of quality by completing weekly audits of things such as infection prevention, medicines management and staffing.
The neurology ward was using the Glasgow Coma Scale (GCS) regularly with patients, to assess impairment to their consciousness. This was used after a patient suffered a head injury.

The trust had recently submitted data to the Acute Medicine annual benchmarking audit (SAMBA17). The report had not been published at the time of our inspection. However, the trust informed us that audit data showed 85% of patients were seen by consultants within 14 hours.

The King’s bone marrow/stem cell transplant service was the largest adult transplant service in the UK and was accredited by the Joint Accreditation Committee-ISCT and EMBT (JACIE). The trust audited their compliance with some of the JACIE and European Society for Blood and Marrow Transplants (EMBT). These were international standards focused on bone marrow transplants. The haematology services audited compliance with JACIE standards around prescribing and administration of treatment regimes.

Services were auditing compliance with NICE guidelines. For example, the haematology department conducted an audit in July 2016 to assess compliance with NICE guidelines for Non-Hodgkin’s Lymphoma (an uncommon cancer that develops in the lymphatic system).

**Pain relief**

We observed staff assessing patient’s pain levels and taking appropriate actions to ensure pain relief was administered in a timely way.

Patient’s pain was usually managed via oral or intravenous (IV) medicines. When patients were in a lot of pain staff could refer the patient to the hospital pain team who were available Monday to Friday.

Assessments of patient’s pain were included in a routine set of observations. Patients were asked to rate the severity of their pain between one and 10. These pain scores were recorded in patient’s records. We checked numerous bedside records across all wards we visited and found pain scores completed for all patients.

Patients told us their pain was generally well managed and that they had received appropriate pain relief in a timely manner. One patient out of 18 told us they had waited a long time for pain relief.

**Nutrition and hydration**

Patient nutrition and hydration was supported by dietitians within the hospital. Patients could be referred for dietetic review if there were concerns about their weight or calorie intake.

Patients who had difficulties with eating and drinking could be referred to speech and language therapy (SALT) or occupational therapy for relevant assistant. We saw evidence of SALT involvement in patient’s nutritional plans in patient’s records. For example, we saw one patient who was at risk of choking on solid food had a SALT assessment and recommendations in place.

Fluid balance charts were used to monitor the fluid intake and output for some patients. We saw evidence that these were put in place and reviewed by staff at regular intervals. Nutritional assessments were included in the nursing risk assessment document. We found these had been completed for most patients.
We saw patients were provided with jugs of water at their bedside and could access hot drinks at intervals throughout the day.

**Patient outcomes**

Between 1 March 2016 and 28 February 2017, patients at King's College Hospital had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average. This helps identify if services were effective. If patients are readmitted it suggests they did not fully recover and required a return visit to hospital.

- Patients in Clinical Haematology had a higher than expected risk of readmission for elective admissions
- Patients in Hepatology had a higher than expected risk of readmission for elective admissions
- Patients in Cardiology had a higher than expected risk of readmission for elective admissions
- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Clinical Haematology had a lower than expected risk of readmission for non-elective admissions
- Patients in Cardiology had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions - King's College Hospital (Denmark Hill)**

![Elective Admissions Chart]

**Non-Elective Admissions - King's College Hospital (Denmark Hill)**

![Non-Elective Admissions Chart]

*Sentinel Stroke National Audit Programme (SSNAP)*
The King's College NHS Trust takes part in the quarterly Sentinel Stroke National Audit Programme. There were two hyper acute stroke units, one at Kings College Hospital and one at Princess Royal University Hospital (PRUH). On a scale of A-E, where A is best, the trust achieved grade E in its latest audit on the 20th July 2017. A decline is visible across several of the Team-centred KI levels. The previous performances indicate the unit is capable of much higher performance.

### Team-centred KI levels

1. **Scanning**
   - A
2. **Stroke unit**
   - D
3. **Thrombolysis**
   - B
4. **Specialist Assessments**
   - A
5. **Occupational therapy**
   - A
6. **Physiotherapy**
   - A
7. **Speech and Language therapy**
   - C
8. **MDT working**
   - C
9. **Standards by discharge**
   - A
10. **Discharge processes**
    - C

#### Team-centred SSNAP level (after adjustments)

- C

#### Team-centred Total KI level

- B

### Overall scores

- SSNAP level
  - C
- Case ascertainment band
  - C
- Audit compliance band
  - B
- Combined Total Key Indicator level
  - B

1 Included in IM reporting, indicator SSNAPD02

### Heart Failure Audit

In-hospital Care Scores

Results for King's College Hospital NHS Foundation Trust in the 2015 Heart Failure Audit were better than the England and Wales average for two of the four of the standards relating to in-hospital care. Cardiology inpatient came in much lower than the national average of 48.1%.
Discharge Scores

Results for King's College Hospital NHS Foundation Trust results were similar to the England and Wales average for six of the seven standards relating to discharge.

All criteria were performing within 5% above or below the national average, with one exception. Referrals for a cardiology follow-up were over 10% higher than the national average.

*National Diabetes Inpatient Audit*
The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year. Quartile one means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 153 inpatients with diabetes at King’s College Hospital. Of these, 74.9% of patients with diabetes reported they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one.

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to the whole trust).

Between April 2014 and March 2015, 22.4% of nSTEMI patients were admitted to a cardiac unit or ward at KCH and 99% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 66%, which was worse than the audit minimum standard of 90%. This was an improvement on the 2015 figure of 51%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.4%. This was significantly worse than the national level, and worse than the 2015 figure, which was 19%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 71.4%; this was slightly above the national level. The 2015 figure was 80%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 78.9% this was significantly better than the national level. The 2015 figure was 57%.

The one year relative survival rate for lung cancer patients for the trust in 2016 was 32%.

National Audit of Inpatient Falls

The crude proportion of patients who had a vision assessment (if applicable) was 3.8%. This fell far below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 10%. This also fell below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 68.2%. This fell below the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 63%. This fell below the national aspirational standard of 100%.

Audit action plans
The trust provided us with an action plan demonstrating what actions they are taking to improve patient outcomes in response to their national audit performance. For example, in response to the falls audit the trust are sourcing risk assessments from other organisations and improving documentation of falls. The trust were also conducting a falls pilot study on six medical wards to adapt the risk assessment and change practice.

**Competent staff**

All new staff were inducted into the trust. The induction programme included the mandatory training staff needed to complete. It also included essential information such as the Kings values; the trusts aims and objectives, policies and procedures and information about health and safety.

All staff in medicine were provided with a local induction in the workplace which helped introduce them to their area of work. There was a local induction checklist that needed to be completed. This covered key areas such as procedures, facilities, key contacts and risks. Bank and agency staff were also inducted onto the ward and we saw records were kept to show they had been properly inducted.

New starters were allocated to a mentor and worked as supernumerary until basic competencies were achieved. Specific competencies had to be signed off for certain tasks like medicines administration.

Newly qualified nurses underwent a period of preceptorship and had assessments to check their competencies in key areas of the staff nurse’s role.

Following this, nurses could be placed on additional courses depending on their speciality. For example, on Charles Polkey Ward staff underwent a six month preceptorship. Following this, they went onto a 12 month rotational neuroscience course rotating between the neurology, neurosurgery and stroke wards within the trust. The lead nurse for Charles Polkey told us nurses could then attend the post registration neuroscience course at King’s College to develop their skills further. This would help prepare them for band six nursing roles.

Throughout medical services staff had access to Clinical Nurse Specialists (CNS) in different areas, such as stroke. These nurses were available to provide advice and support for patients and staff.

A team of practice development nurses (PDNs) provided educational learning and teaching to staff. They also helped to monitor mandatory training on wards and were involved in the recruitment of overseas nurses.

Junior doctors we spoke with said they felt supported by consultants and they could access consultants for help and advice where necessary. There was access to training on a regular basis for development.

Between June 2016 and May 2017, 48% of staff within King’s College Hospital had received an appraisal compared to a trust target of 90%. 161 entries within the data set provided to us had been left blank for a number of appraisals carried out. This could indicate incomplete data recording of this material. It is possible this has caused the low percentage score within the site. A split by staff group can be seen in the graph below:
The trust was working with the educational department to facilitate local training in areas where there were requirements for improvement identified through audit, such as feedback from Never Events.

**Multidisciplinary working**

Board rounds were held on a daily basis on the medical wards and were attended by the multidisciplinary team (MDT). All staff we spoke with said there was good MDT working between nursing, doctors and therapists. Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.

There was good communication between different professions and staff said they respected each other’s expertise and input.

The service had a well-established multidisciplinary approach to care provision. There were daily board rounds and ward rounds with the wider team including medical, nursing, therapy and social care staff.

Medical services had access to a social worker who helped facilitate patients discharge in a safe and timely way.

There were twice weekly virtual ward rounds for patients with diabetes, which included specialist medical and nursing staff. The ward round helped identify high risk patients. In response to
adverse events, tailored education programs had been given in specific areas around the hospital. These education programs had been multidisciplinary.

On the stroke unit where there are patients requiring complex care, MDT working helped to ensure good care and appropriate discharge so patients’ ongoing needs could be met.

Cancer services operated on a MDT approach with regards to decisions around treatment. The MDT consisted of a range of specialists from across the oncology pathway and partners from the cancer centre.

**Seven-day services**

Consultants provided seven day services across medical services and led daily ward rounds in acute medicine services. There was access to consultants of other specialities via a bleep system seven days a week. Data provided by the trust from March 2017 indicated that around 88% of patients who required twice daily consultant reviews received them.

Physiotherapy services were available seven days a week by a dedicated physiotherapist’s team; an on-call physiotherapist was available out of hours.

Occupational therapists were available seven days a week. There was also access to pharmacy seven days a week and pharmacists attended patient ward rounds.

The trust had introduced a seven-day matron service so at weekends there was always a matron available, which improved presence of senior nursing leadership.

The iMobile team was available seven days a week 24 hours a day to assess and provide support for deteriorating patients on wards.

Speech and Language Therapists (SALT) and dietitians were available Monday to Friday.

Endoscopy clinics were available five days a week (Monday to Friday). We were told there were plans to increase this to be a six day a week service.

**Access to information**

Clinical staff were able to access electronic patient records from across the hospital, which required a staff log in. Due to the log in requirement, agency staff were unable to access patient’s medical records. This meant agency staff could not read clinical notes online and could not input their nursing notes onto the system.

Staff were able to access diagnostic results such as bloods and imaging to support the care and treatment of patients. Due to the removal of junior doctors in radiology this had had an impact on the time taken for the staff to get a report of the results from this department.

Staff had access to policies and procedures via the trust’s intranet page and there was good access to trust computers in order to access this information. Agency staff did not have computer log in, so it limited their access to online policies and guidelines.

On discharge, patients’ discharge summaries were produced and shared with the patient’s general practitioner (GP).
During handovers staff discussed each patient whilst using a patient flow board. This contained key information such as diagnosis and patients care plans for the day including any tests and diagnostics. It also incorporated a section for ‘Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)’ so staff could check whether patients had their DNACPR status recorded. This would then prompt staff if patients’ statuses were not recorded.

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

The trust reported that between June 2016 and May 2017, Mental Capacity Act (MCA) training had been completed by 74% of eligible staff within King’s College Hospital.

Data around provision of deprivation of liberty training was not provided and was not available at the time of this report.

Most staff demonstrated a good knowledge of the principles of informed and implied consent as well as the Mental Capacity Act (2005) in relation to patients with dementia.

Most staff were familiar with Deprivation of Liberty Safeguards (DoLS) and we saw evidence of DoLS assessments and applications in use on medical wards. Appropriate capacity assessments were completed prior to DoLS.

On one ward, a patient was being ‘specialed’ due to an increased risk of falls. This meant there was a staff member who sat with them throughout the day. Due to the potential that this patient would require longer term ‘specialising’, staff were in discussion about applying for a DoLS to ensure they were not inappropriately restricting the patient’s liberty. This was good practice.

However, on RD Lawrence Ward, understanding of the MCA and DoLS was variable. Staff said there were a lot of mental health patients on this ward but limited training around mental health and the mental capacity act.

Staff were aware of the need to obtain consent from patients to complete a variety of tasks, for example we saw one staff member asking a patient for consent to take their blood pressure.

Endoscopy services were following appropriate procedures regarding consent and had trained some nurses to take consent for minor procedures.

**Is the service caring?**

**Compassionate care**

The Friends and Family Test (FFT) was given to patients to determine whether they would recommend the medical services provided by the hospital to their family and friends.

The FFT response rate for Medicine at the trust was 30%, which was better than the England average of 25% between 1 July 2016 and 30 June 2017.

**Friends and family Test – Response rate between 01/07/2016 and 30/06/2017 by site.**
The below table breaks down the friends and family test on a ward by ward basis across King’s College Hospital:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp</th>
<th>Ave Resp rate</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Byron</td>
<td>219</td>
<td>25%</td>
<td>66%</td>
<td>88%</td>
<td>89%</td>
<td>97%</td>
<td>89%</td>
<td>95%</td>
<td>100%</td>
<td>85%</td>
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<td>0%</td>
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<td>0%</td>
</tr>
<tr>
<td>Cotton</td>
<td>217</td>
<td>23%</td>
<td>100%</td>
<td>94%</td>
<td>93%</td>
<td>90%</td>
<td>97%</td>
<td>0%</td>
<td>91%</td>
<td>89%</td>
<td>91%</td>
<td>0%</td>
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<tr>
<td>DHI-The Children’s Surgical Unit</td>
<td>300</td>
<td>42%</td>
<td>95%</td>
<td>86%</td>
<td>90%</td>
<td>84%</td>
<td>97%</td>
<td>95%</td>
<td>96%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
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</tr>
<tr>
<td>Deacon</td>
<td>481</td>
<td>53%</td>
<td>98%</td>
<td>100%</td>
<td>86%</td>
<td>97%</td>
<td>93%</td>
<td>89%</td>
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<td>98%</td>
<td>96%</td>
<td>92%</td>
<td>89%</td>
</tr>
<tr>
<td>Donnie</td>
<td>201</td>
<td>49%</td>
<td>86%</td>
<td>100%</td>
<td>85%</td>
<td>89%</td>
<td>100%</td>
<td>93%</td>
<td>82%</td>
<td>93%</td>
<td>94%</td>
<td>74%</td>
<td>89%</td>
<td>95%</td>
</tr>
<tr>
<td>ELF &amp; LIBRA Ward</td>
<td>124</td>
<td>29%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
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</table>

All wards were still asking patients and relatives to complete the ‘How Are We Doing’ patient feedback form prior to discharge to obtain patient feedback about their experience of the medical service. We saw some wards had the results of this displayed and included information about what actions the ward was taking to make improvements based on feedback.

Medical wards were included in an audit of the trusts Bereaved Carers Questionnaire between April 2015 and March 2016. Generally, carers said they would refer the services at King’s College Hospital to other people. They were positive about the way staff spoke with them and were happy with the amount of information and support they received.

We saw examples of conversations regarding how a patient’s care and treatment were managed in a compassionate way. There were quiet rooms available where staff were able to have sensitive conversations with them and relatives if required.
On occasions, some patients became distressed and we saw staff managing such situations in a calm way until the patients became more comfortable. We observed several interactions between staff and patients and saw staff speaking to patients in a kind manner, and they listened to what patients had to say.

Patient feedback was complimentary overall, with patients describing medical wards and their staff as: “Nurses and doctors are wonderful and make an effort to chat to me”, “They are never too busy to look after you”, “The staff are friendly and have a good sense of humour”.

We saw numerous thank you cards across the wards we visited with comments such as: “Staff do amazing things everyday”, “Nothing is ever too much”, “There is kindness, jokes, information”, “Great companionship, kindness and support”, “The professionalism, care and compassion the service has shown is simply fabulous”. On Elf and Libra Ward, one patient had said the ward “Is a credit to this hospital”.

We saw patients were treated with respect including when they were receiving personal care or undergoing an invasive procedure. The majority of patients said their dignity and privacy was respected at all times.

Patients with mental health illnesses were often admitted onto medical wards. For example, on Annie Zunz Ward, there were patients with a mental health diagnosis on the ward. Staff were non-judgemental and able to access registered mental health nurses (RMN) for additional support.

A few concerns were raised by patients. One patient on Byron Ward said “Some staff are nice but some are not”. A patient on Oliver Ward said “Sometimes staff pretend they can’t hear you when they are busy”.

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

We observed doctors on ward rounds offering patients the opportunity to ask questions and to clarify anything they were unsure of. Patients said they were given opportunities to ask questions and these were answered by staff. Patients and relatives told us staff would always explain things in a language they could understand.

We observed positive interactions between doctors, nurses, therapists and patients. On one ward, we saw physiotherapists questioning a patient regarding falls they had had prior to being admitted to the hospital. They did so in a kind and supportive way and helped reduce the anxiety of the patient during the conversation.

Patients and relatives told us they were kept well informed and up to date regarding their care and treatment. They told us they were given many opportunities to ask questions and staff were always available to answer questions and provide information. For example, a patient on Longsdale Ward told us “The nurses always have time to chat and have explained the next steps clearly to me”. On Waddington Ward, we were told by a patient “The nurses and doctors are accommodating and explain everything clearly”.

However, on Annie Zunz Ward, a patient and relative raised concerns that “The staff seem rushed off their feet” and “Doctors come in the morning when the family are not there so we do not know what is going on”. A second patient said “The doctor said they would come and give me some information but they haven’t yet”.
On the health and aging wards such as Marjory Warren, we saw staff were using ‘All About Me’. This was information displayed at each patient’s bedside. This included information about things the patient liked and did not like, such as food preferences.

On Donne Ward we observed staff members asking patients for consent before carrying out any procedures, for example, taking a patient’s blood pressure.

Relatives we spoke to were happy with the care their relatives received and felt they had been kept well informed about care and treatment. For example, one relative told us a doctor had provided them with information about a range of medications.

We saw some medical wards were using ‘Patient Stories/Compassion in Care’ which was a framework used to help assess quality of care for patients. Staff would go out and speak to patients and complete a document that asked about things such as their care experience, information sharing and facilities. This was then fed back to the ward.

We had some concerns raised about information sharing. One relative said the staff had taken blood samples without informing them. A second relative said a patient had been referred to and visited by the End of Life Care (EoLC) team without the families’ involvement.

**Emotional support**

On the haematology wards, there was a weekly support group for family members and carers called ‘Caring for the Caregiver’. This gave carers the opportunity to discuss their experiences and discuss how to cope when caring for patients with these types of illnesses. The group ran on a weekly basis and was facilitated by one of the wards counsellors.

Haemo-oncology wards also had access to their own counsellors who were available for all patients on the wards.

There was a chaplaincy service at King’s College Hospital which offered support to patients and their relatives and carers. They provided spiritual and religious care regardless of belief. We saw information leaflets about the chaplaincy service throughout the medical wards in the hospital.

Staff were able to refer to the psychiatric liaison service within the trust if support was needed to assess mental health needs of patients.

**Is the service responsive?**

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

If patients were admitted and suffered diabetes they could be referred to the diabetes inpatient service. Patients would be referred to a diabetes specialist registrar and triaged by a diabetes specialist nurse. The medical admissions wards offered electronic screening for patients with diabetes to facilitate early intervention.

Senior leaders acknowledged the increased need for elderly care and medicine beds within the hospital. This had led to one of the surgical wards being changed to become a medical ward. This
ward was currently undergoing a refurbishment and would include eight beds specifically for older people.

Between June 2016 and May 2017 the trust reported no mixed sex accommodation breaches. A mixed sex breach occurs when a male and female patient were cared for in the same clinical area. During the inspection we saw no mixed sex breaches.

There were relative rooms and quiet rooms available on medical wards for relatives and patients to use. However, one patient said these rooms were also used by staff which prevented them from using it.

Visiting times on medical wards were between 2pm and 8pm, with protected times scheduled at lunchtime as well as the evening meal and some designated quiet time for patients.

We visited Davidson Ward (Haematology) and were shown a newly opened ambulatory care unit for patients requiring bone marrow transplants and chemotherapy. Ambulatory care is a patient focused service in which treatment can occur without the need for an overnight stay on the wards. Patients were risk assessed and were able to start their treatment using this unit. This meant they could stay at home or in a hotel for the first few days rather than the hospital. Once the immune system was lowered, patients would then be admitted to the main wards. This gave patients more time at home and less time in the hospital. It also helped improve bed access on the wards.

Meeting people’s individual needs

The Trust had plans to meet with DisabledGo, a service that aimed to maximise independence and choice for disabled people in accessing their local area including hospitals. There were plans for them to assess all of the trust sites and provide comprehensive access information via their website for disabled people when they visit the wards.

Staff said patient information was available in different formats or languages as required. Patients were advised to contact the Patient Advice Liaison Service (PALs) if they required information leaflets in a language other than English.

Staff were able to access interpreter services for patients whose first language was not English. Staff could book interpreters for face to face meetings or over the phone. We asked one staff member how they accessed interpreters for deaf patients and they told us they would make a referral to the trust in order to be able to access this.

The patient feedback forms were available in other languages and easy read versions for people with communication difficulties. Staff told us they could access Speech and Language Therapy (SALT) for patients with learning difficulties or communication impairment.

At the time of our inspection, the trust was trialling the ‘forget me not’ scheme on the patient’s electronic record system. There were hopes this would be rolled out to all medical wards and improve how the trust identified patients with dementia.

There was a dedicated Dementia and Delirium Team (DaD) which consisted of specialist nurses and the support of a consultant geriatrician. The team worked closely with the King’s Older
Peoples’ Assessment and Liaison Service (KOPAL) and old age liaison psychiatry. Staff across medical wards were able to refer patients to the DaD team if they required support for patients with dementia.

On the inspection we saw one ward had made use of different colour walls for patients with cognitive impairments, such as dementia. This meant patients could easily identify which bay they were in. There was a sensory room and sensory wall on Marjory Warren Ward for patients living with dementia.

However, not all health and aging wards were dementia friendly. In order to make some medical wards more dementia friendly the trust had developed an environmental specification group with the aims of improving facilities for dementia patients.

There was a learning disability clinical nurse specialist (CNS) within the trust whom staff could access if required. When patients were flagged as having a learning disability, the referral was emailed to the learning disability nurse within the trust’s safeguarding team.

There was a staff guide available about ‘safeguarding adults at risk and people with learning disabilities’. This provided information about the different types of abuse and what to do if staff suspected patients were at risk.

There were no specialist nurses for patients who were blind or deaf.

Relatives and patients had access to a multi-faith chaplaincy service and we saw information on how to access this was displayed on medical wards.

Most patients we spoke to were happy with their food choices on the wards. We reviewed patient menus and saw a range of options for specialist diets including vegetarian, gluten free and softer options.

We observed patient lunchtimes on some of the wards we visited such as Marjory Warren Ward. Patients who had any difficulties with eating were given red trays to indicate that they needed assistance during meal times. We saw patients were supported during meal times the majority of time by staff. However, on one occasion we saw soup was placed out of reach for one patient.

We saw some patients had signs above their bed indicating their food preferences to staff. For example, one patient had a sign above their bed saying ‘no fish’. This helped make staff aware of food preferences when supporting patients to pick their food from the menu.

There was a ‘Home Hamper Scheme’ within the trust run by the King’s Volunteers Programme. This service offered patients food parcels to take home on discharge from the hospital to ensure they had something to eat. We saw information about this service displayed on some of the medical wards.

On Davidson Ward, we saw some groups for patients had been run prior to our inspection including yoga and a head scarf wrapping/tying workshop for patients with hair loss.
Staff on Longsdale Ward (respiratory) had done a fund raising event and purchased an exercise bike for patients to help with their lung function.

The head of nursing for neuroscience told us patients would be able to access a rooftop garden which was being developed. This would give longer-term patients easier access to outdoor space.

Patients were mostly happy with the environment. However, on Mary Rae Ward some concerns were raised regarding beds that were close to the nurses’ station and door entrance. Patients said it was very noisy and prevented them from sleeping at night. They could also overhear staffs’ conversations.

Access and flow

Patients accessed medical services after becoming unwell at home and being admitted via the emergency department or through booked admissions for planned treatment.

Between 1 April 2016 and 31 March 2017 the average length of stay for medical elective patients at King's College Hospital was 5.3 days, which was higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.8 days, which was higher than England average of 6.7 days.

- Average length of stay for elective patients in Hepatology is higher than the England average.
- Average length of stay for elective patients in Cardiology is higher than the England average.
- Average length of stay for elective patients in Neurology is lower than the England average.
- Average length of stay for non-elective patients in General Medicine is higher than the England average.
- Average length of stay for non-elective patients in Clinical Haematology is lower than the England average.
- Average length of stay for non-elective patients in Cardiology is higher than the England average.

Elective Average Length of Stay - King's College Hospital (Denmark Hill)

Non-Elective Average Length of Stay - King's College Hospital (Denmark Hill)
Referral to treatment (percentage within 18 weeks) - admitted performance

The trust performed in line with or just below the national average. Referral to treatment percentages did not fall below the 80% mark and often match the 90+ % national average, particularly between November 16 and March 17.

Insert commentary of trend over time.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>97.9%</td>
<td>94.4%</td>
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</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
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<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>87.5%</td>
<td>98.1%</td>
</tr>
<tr>
<td>Neurology</td>
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<td>92.2%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>73.7%</td>
<td>93.8%</td>
</tr>
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</table>

In the trust’s annual report 2017/17, they reported data around cancer waiting time standards. Cancer standards cover the time from GP referral to the first appointment with a cancer specialist (the 2 week rule), 31 days from diagnosis to treatment; and 62 days to first treatment from referral. For the first half of the year the trust were assessed based on its performance against the two week rule and 62 day target via Monitor’s Risk Assessment Framework with performance assessed quarterly. In the second half of the year this changed to assessment via NHS Improvement’s Single Oversight Framework and assessment was based on monthly compliance for 62 day targets only.

The report showed that with the exception of breast cancer (88.9%) in quarter 1 (April to June 2016), cancer two week targets were maintained during the first half of the year. The trust’s target was 93%. Between October and March 2017 the trust has reported their data monthly which showed greater variability of between 79% and 94% for the 62 day targets.
In the previous six months the division had taken action to address the long waits for neurology services. They had taken on three new substantive neurology consultants and also appointed a locum to enable them to increase the number of general neurology clinics running across hospital sites. Within the Transformation Project that had been started, the trust were also reviewing DNA’s and partial bookings. The trust was looking at introducing ‘hot clinics’, which should enable them to significantly reduce waiting times over the next 12-18 months.

Consultant connect had commenced so they could discuss cases with GPs to ensure appropriate cases were referred. In addition they had developed headache guidelines for GPs in Bromley, Southwark and Lewisham to help them manage primary headache in the community, and were also developing guidelines for seizures / blackouts. They were due to start a pilot community headache service in Bromley and had already done an educational half day to Bromley GPs on this. They have developed new pathways at DH for patients referred on the 2-week-wait suspected cancer pathway enabling them prompt access to imaging.

Between June 2016 and May 2017, 61% of individuals did not move wards during their admission, and 39% moved once or more.

We reviewed some trust data regarding the number of patients who were moved wards overnight (between the hours of 10pm and 8am). Between June 2016 and May 2017 the wards with the highest number of overnight bed moves were Annie Zunz and RD POST Lawrence Ward.

Between September 2016 and August 2017 there were 217 (2.4%) of patients who were moved wards more than four times throughout their stay.

There was a clear bed capacity escalation plan to ensure optimal management when bed capacity was an issue. We attended the site team meeting which brought together various divisional bed managers to discuss patient flow in the hospital.

On day two of the inspection, senior leaders told us there were three medical outliers. This was when a patient was not placed in the appropriate speciality ward. We were told safety huddles were happening on a daily basis to ensure outliers were not an issue. We were told wards were being reconfigured to become more speciality focused so patients could get to the right area at the right time.

Within haematology, an ambulatory care unit had been opened for patients requiring bone marrow transplants and chemotherapy. This gave patients the opportunity to start treatment without requiring a bed which helped with capacity issues and flow.

Discharge plans were commenced on admissions and we saw discharge was discussed in handovers and board rounds. We attended the hospitals bed management meeting and saw discharge and any obstacles to discharge were discussed.

Patients who required mental health assessment were referred to the psychiatric liaison service. Between January and April 2017 data indicated that the majority of these patients had their assessment within three hours of referral (between 70% and 81%) in hours. For out of hours patients between 80% and 86% of patients were assessed within three hours.

**Learning from complaints and concerns**

Between June 2016 and June 2017 there were 650 complaints about services at the King’s College Hospital at a trust level. The trust took an average of 94 days to investigate and close
complaints. This was not in line with their complaints policy, which stated complaints should be resolved within 25 days.

Several of the complaints had no resolution date added. It is unknown at this time if this indicated they were incomplete or whether there was a deficiency in the data supplied.

We reviewed complaints data for the medical wards we visited during the inspection. Between July 2017 and August 2018 we counted 76 complaints. The most common types of complaints were around clinical treatment, admission, discharge and transfer and patient care.

We saw leaflets on how to make a complaint and information about the PALS service available across medical wards. Patients were told to access the PALS service if they were unable to deal with their complaint at a ward level.

We reviewed a response to a complaint made on Annie Zunz Ward. Within this letter, the service had apologised to the patient and provided an explanation of what changes were being made to make improvements. For example, a reflection session was to take place with staff around pain management.

Is the service well-led?

Leadership

There had been a two year restructuring taking place since we last inspected medical care services and this had officially been in place since March 2017. Whilst senior leaders told us they were ‘still finding our feet’, we saw good strong leadership which supported staff and was facilitating improvement.

Medical wards and specialist medical wards were in two separate divisions. Medical services including health and aging services fell under the Urgent and Planned Care division. This was split into acute and post-acute services. Both acute and post-acute services were led by their own clinical director, head of nursing and matrons. The trust had also recruited into ward manager posts to help improve services.

Specialist medical wards such as neurology and haematology were part of the networked division. They were led by a clinical director and head of nursing. Each specialism had a nursing lead and matron leading the service. For example, neuroscience had a matron for neurology and a matron for stroke and haematology had a matron. Wards also had ward managers.

Staff said managers were supportive and approachable. A number of staff highlighted that they had seen good changes over the past few months since the new leadership team had come in place. For example, Oliver Ward had been closed down earlier in the year due to a serious incident and some issues with staffing levels and staff attitudes. Staff we spoke to on Oliver Ward said they had seen significant improvements since the ward was reopened. This included staff saying the leadership was more present and more responsive to staff raising any concerns.

Across all wards, staff told us the leadership team were present on the wards. The heads of nursing, matrons and ward managers were visible throughout services and staff said they felt comfortable approaching them if they had any issues they wished to raise.
A number of staff were also very positive about the director of nursing who they said was present across wards and supportive.

**Vision and Strategy**

There was evidence of a local strategic document, which outlined key areas for improvement and the leadership team’s vision for the services. Specialist services such as neurology and haematology had their own detailed strategies for service development including research and education.

Senior leaders within the urgent and planned division told us there was a five year environmental strategy within the trust. Over the next five years medical wards were going to be modernised and updated to improve the environment.

Medical service leaders wanted to improve access to level one care. This was due to flow issues when critical care patients needed stepping down onto medical wards.

In order to prepare for winter pressures the trust had completed a period of ward movements. Twining Ward was closed at the time of our inspection, which was previously a surgical ward. The ward was undergoing a refurbishment and would be reopened as a new medical ward to help with patient flow, come the winter months. The trust was also doing work around capacity on medical wards in preparation for winter. The vision was that by making wards more specialist focused, it would mean patients getting to the right areas at the right time and prevent patients being moved too many times during their stay.

As per national recommendations from NHS England, the trust had a vision to improve routine frailty assessments and identification. This included frailty assessments in the emergency department and introducing eight frailty only beds in Twining Ward once it opened.

In April 2016, King’s College Hospital NHS Foundation Trust developed its “BEST” strategy, putting patients first and aiming to provide them with the very best care and services globally. The ambition was to be an outstanding local hospital at the heart of the communities that the trust served and a world-class centre for specialist clinical, teaching and research excellence.

Staff knew how their work contributed to the wider vision of the trust and they were aware of the trust values. Staff told us values were discussed during the trust induction and were embedded in their practice. The trust had also launched an internal engagement campaign to increase awareness of the trust’s vision and strategy and the Chief Executives weekly note was a way in which to reinforce this.

Due to the high number of mental health patients admitted to medical services in the trust, senior leaders told us they wanted to integrate physical and mental health pathways. A new meeting called the ‘Mental Health Board’ was being set up which would be chaired by the lead psychiatrist within the trust. The purpose of the board was to help look at how the services could deal better with challenging and aggressive patients and better manage mental health patients admitted onto the wards. Senior leaders highlighted the need for more local mental health training for staff.

**Culture**
Staff described a ‘no blame’ culture and told us they were encouraged to report clinical incidents. There was a proactive culture in learning from incidents and sharing information and staff were able to identify changes as a result of incidents.

The majority of staff reported a positive culture and were enthusiastic about the care and services they provided for patients.

Since the leadership team had come into place, staff had started to notice positive changes in their area of work. This included improved presence of nursing leadership and better responses to concerns.

However, on Mary Rae Ward, a patient told us they could overhear staff discussing other staff members they were not happy with. The patient said it was “back stabbing and gossiping” and highlighted this wasn’t something a patient should have to hear.

We observed excellent multidisciplinary working between doctors, nurses, therapists and patients to ensure good outcomes for patients.

On RD Lawrence Ward, a staff member came into the treatment room and complained openly about an agency member of staff in front of us. The staff member said “they are of no use” to a more senior colleague. We observed the other staff member appropriately challenged this comment as inappropriate.

We spoke to some ward clerks who said they did not always feel valued by medical staff and the trust.

One consultant said that due to financial issues, they were unable to do some of the things they wanted to do within the service, such as research.

**Governance, Management of Risk and Quality Improvement**

It was clear the service had taken steps to address some of the issues identified during our previous inspection, such as staff’s knowledge around sepsis identification and management. Staff of all levels were all working towards the same goal of improving the medical services for patients.

Within the urgent and planned care division, there were acute and post-acute services. Both these services had their own separate governance structure that fed into the overall divisions’ structure. Both acute and post-acute services had a monthly clinical governance meeting and within this, there were also local level governance meetings which were also on a monthly basis. For example, health and aging services had their own specialist clinical governance meetings once a month.

In the Networked Services division specialist, services had their own clinical governance meetings on a monthly basis, which they fed into the divisional clinical governance group. For example, neurosciences met as a whole service which included medicine, surgery and stroke services.
Within clinical governance meetings, a range of topics were discussed including incidents and risk management, serious incidents and investigations, any trends within services such as falls or violence and aggression, recruitment and audits.

Charles Polkey Ward and other neuroscience services met monthly to discuss any risks as a whole department. This would then feed into the monthly clinical governance meeting.

We saw health and aging services had a ‘Safety in Clinical Gerontology Newsletter’ which was disseminated to staff. This included information about risks, serious incidents and learning from incidents.

Potential risks for medical services were recorded on the divisions risk register and discussed in governance meetings. We reviewed the services risk register and saw that the risks identified by us during the inspection were risks services leads had identified within medical services. There were appropriate mitigations in place to reduce risk and risks were reviewed on a regular and ongoing basis.

During the inspection we met with the senior leaders of the urgent and planned care division and asked them what they thought were the biggest risks to the medical services. We found the senior leaders had a good oversight of some of the risks we found in the service. For example, staffing, recruitment and retention, and falls. Senior leaders also highlighted mental health awareness and staff management of violent and aggressive patients as a key concern.

Staff understood their role and function within the hospital and how performance enabled the organisation to reach its objectives.

Public and Staff Engagement

The trust had a range of methods around patient engagement including patient surveys and patient stories.

Specific work was going on to improve the frailty pathway across the trust and there were links with local Healthwatch to undertake interviews with frail, older people to gather their views on how to ensure the pathway worked.

As part of the cancer patient experience priority, the trust said they were holding listening events for cancer patients and their families with the view of setting up a permanent patient panel for cancer.

Staff told us they had regular ward meetings where a range of items were discussed including staffing and learning from incidents. In addition, this gave staff the opportunity to raise any concerns or issues identified in their service.

The trust participated in the NHS staff survey and senior leaders of medical services highlighted staff engagement as a key issue identified by the survey. The service was aiming to improve staff engagement by improving communication, presence of leadership and improved support. Staff we spoke with reported some improvements since the new leadership team had been in place.
Staff told us there were trust wide recognition awards for staff.

**Learning, continuous improvement and innovation**

Medical wards were participating in a ward accreditation scheme in which wards were accredited once they were meeting a range of standards. Wards were scored on a percentage which highlighted whether they were accredited or whether there were still improvements that needed to be made. Information about what the ward were doing well and what the wards needed to do to improve was displayed on the wards information boards.

There were pioneering services in neurosciences and haematology. For example, on Charles Polkey Ward (neurology), we were told the clinical nurse specialist (CNS) was currently conducting a longitudinal piece of research around brain injury. The project was looking at the importance of early family therapy for patients with new brain injuries and the links with breakdowns within families.

The trust had pioneer a number of innovative endoscopic procedures including ‘endobarrier’ (for patient with obesity and type 2 diabetes), per-oral endoscopic myotomy (for treatment of achalasia) and Revita (for treatment of type 2 diabetes via ablation of the duodenum).

The hospital had a developed novel diabetes prescribing systems, introducing insulin order sets which helped ensure appropriate insulins were prescribed at the appropriate times, giving King’s (KCH) a lower than average rate of insulin prescription errors.

To help reduce hospital admissions kings was conducting a trial of a programme called ‘CF at home’. Within this programme patients with diseases were cared for outside the hospital by members of the multidisciplinary team. The purpose of this programme was to focus on prevention and behaviour change to support adherence to treatment.

Haematology had recently introduced a new model of ambulatory care for patients undergoing chemotherapy and autologous stem cell transplantation. Patients who lived within 30 minutes’ drive in busy traffic could stay at home and travel to the Ambulatory Care Unit for medical and nursing care every day for their treatment. Patients who lived outside this radius were accommodated in a local hotel along with their partner or responsible carer. Patients benefited by being able to continue daily life away from the hospital and spend time with friends and family, enjoying a greater sense of normality and independence than if the treatment meant staying in hospital for the whole time.

Chimeric Antigen Receptor (CAR-T) cells therapy is an exciting new type of immunotherapy that has great promise for the treatment of cancer. Clinical trials so far have used CAR-T cells derived from patients (autologous CAR-T cells) but the manufacturing process can be time consuming, expensive and not always successful. This means it is not always possible to use them in time for patients who have rapidly progressive disease. ‘Off the shelf’ allogeneic CAR-T cells generated from healthy donors are therefore being developed which can be manufactured anytime and be readily available to be sent to a patient needing treatment. Kings College Hospital was running a phase one trial (CALM study) evaluating the world’s first off the shelf CAR-T cell product (UCART19) in patients with relapsed B-acute lymphoblastic leukaemia.
Facts and data about this service

Kings College Hospital carried out 46,310 surgical procedures between April 2016 and March 2017. Of these, 24,337 (53%) were day cases, 12,048 were emergency (26%) and 8,763 (19%) were elective. There are 20 theatres in general surgery and seven in the Day Surgery Unit. There are six surgical wards with a total of 125 beds. Kings College Hospital has a Day Surgery Unit and a recently opened Surgical Assessment Unit.

We visited four theatres and six wards over two days during our unannounced inspection and we observed care and treatment. We visited the Day Surgery Unit and the Surgical Assessment Unit. We looked at 16 sets of patient records. We spoke with 35 members of staff, including nurses, doctors, allied health professionals, pharmacists, managers and support staff. We had an Expert by Experience on our team who spoke with 16 patients five relatives and five members of staff. Experts by Experience are people who have experience of using or caring for someone who uses health and/or social care services. The role involves helping us hear the voices of people who use services during inspections and Mental Health Act visits.

We also used information provided by the organisation and information we requested following our inspection.

Is the service safe?

Incidents

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between June 2016 and June 2017, the trust reported four incidents which were classified as never events for surgery.

The trust had carried out root cause analysis (RCA) on all these events and added additional safety measures where appropriate. For example a RCA was undertaken for a never event relating to a retained swab incident in theatres. This identified the cause of this never event to be a lack of thorough swab count protocols.

Recommendations from this incident included adding an additional reminder in the World Health Organisation (WHO) surgical safety checklist about swab counts and a wall swab holder to help the surgical team to count the swabs. The latter had not yet been implemented in theatres.

Staff we spoke with were aware of the incident and the additional safety checks. They told us they felt the new checking system was more robust as a result. Staff involved in the incident also wrote reflective statements and all staff were encouraged to speak up about concerns in future.

Similarly, a never event relating to insulin administration, due to the use of incorrect syringe device, had been investigated by the trust. Staff told us learning from the incident had been shared during handover. Staff were also given re-fresher training regarding insulin administration.

(Source: Strategic Executive Information System (STEIS))
Between June 2016 and June 2017, the trust reported four incidents which were classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between June 2016 and May 2017.

Of these, the most common type of incident reported was

- Treatment delay meeting SI criteria with 10 (33% of total incidents).
- Slips/trips/falls meeting SI criteria with 8 (27% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with 5 (17% of total incidents).
- All other categories with 3 (10% of total incidents).
- Pressure ulcer meeting SI criteria with 2 (7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 2 (7% of total incidents).

Incidents logged on the IT system were reviewed and investigated to identify improvements required for the surgical service. Serious incidents were investigated by staff with the appropriate level of seniority and expertise, such as clinical leads, matrons or ward managers.
We saw evidence to show these incidents were investigated and actions were implemented.

For example, on the Katherine Monk Ward we heard of three SIs which had been investigated. One incident related to a patient fall and the root cause analysis recommended a new handover process for patients at risk of falls as well as encouraging more feedback to agencies about their staff. Another SI related to a deteriorating patient where the investigation recommended a new process for handovers and additional blood test procedures were put in place. The third was a grade 4 pressure ulcer incident and the ward manager was currently awaiting feedback from the tissue viability team on how to improve their practice.

Recently there had been a significant issue on some of the wards about aggression and violence towards staff from patients. Staff told us these types of incidents were very common and felt almost “part of the job.”

However, all staff we spoke to told us they filled out incident reports whenever these events occurred. They told us they felt supported by ward management and were confident in raising their concerns to them. We were told the on-site security team were very responsive to ward staff when they required assistance with managing aggressive or violent patients.

Staff, of varying levels of seniority, we spoke with knew of the duty of candour principles and how to apply them. Duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide appropriate support to that person or persons. Staff gave examples of when they had applied its principles and spoken with patients directly when mistakes had been made.

Serious incident reports we looked at showed that the duty of candour principles were applied including a letter of apology and explanation to the patient (or other relevant persons) from the clinician in their care and treatment.

Patient deaths were reviewed by individual consultants and were also discussed at monthly mortality and morbidity meetings and divisional quality and safety meetings. Any concerns or learning identified was passed on to individual teams.

(Source: Strategic Executive Information System (STEIS))

Staff were aware of the process for reporting any identified risks. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system. Staff had good knowledge of what an incident was and the different levels of risk they posed to patient safety.

Serious incidents were discussed during daily handovers, and monthly staff meetings. On the Katherine Monk Ward they had implemented the “Tea at 3” meeting for staff to raise any concerns. Learning from incidents was also shared through hospital-wide alerts via email and monthly newsletters on the trust’s staff intranet page.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

It was agreed with the Commissioners from the Clinical Commissioning Group (CCG) in 2015 that the trust would cease to use the Safety Thermometer. This was because the trust already recorded incident data for falls and pressure areas through an alternative method.
The trust had adapted a new electronic app, called ‘Perfect Ward’, to give staff direct access to performance data. This allowed ward managers and matrons to keep track on their surgical area’s performance and act accordingly. The data included hand hygiene audit results, infection control audit results and incident data.

Information from the Perfect Ward findings was shared at ward meetings and via email to senior staff. Ward managers and matrons raised any concerning themes with the rest of their teams and implement changes as necessary.

Perfect ward data was routinely refreshed with some key performance indicators being updated daily. This data included numbers of patient falls on surgical wards, hospital acquired pressure ulcers and catheter associated urinary tract infections (CAUTIs).

Between September 2016 and August 2017, the surgical wards at KCH saw an average of 13 falls per month. This data was refreshed monthly. Though this figure was high, the trust was taking steps to tackle to numbers of falls on surgical wards. We observed patients at risks of fall were discussed at handover meetings and in monthly ward meetings. We saw thorough risk assessments for patients at risks of falls, which were regularly reviewed, and interventions were in place to minimise the risk.

Between September 2016 and June 2017, the surgical wards at KCH saw an average of four hospital acquired pressure ulcers a month. This data was refreshed monthly.

Information was collected with regard to urinary infections acquired as a result of having an indwelling catheter into the bladder. A catheter audit was undertaken in the surgical division at KCH over two days in June 2017. Catheter acquired urinary tract infections (CAUTIs) were confirmed in two instances and, in a two further cases, a positive urine sample was identified but a CAUTI was not confirmed on further investigation. Results suggested that CAUTI rates within the surgical division were low (1%).

**Cleanliness, infection control and hygiene**

The wards and theatres were inspected were visibly clean and safe. Cleaning schedules were in use and there were clearly defined roles and responsibilities for cleaning and decontaminating equipment and for cleaning the environment.

Staff were aware of current infection prevention and control (IPC) guidelines and how to access to the trust’s policies on the intranet ‘Kwiki’ pages.

Any incidents relating to IPC were discussed at monthly, surgery-specific, clinical governance meetings. These meetings were also used to discuss any IPC concerns placed on the KCH surgery specific risk register.

On wards and in theatres, staff told us they had IPC link nurses. Their role was said to include checking that staff followed policies and procedure and also undertaking IPC checks, such as hand hygiene monitoring and checks on the cleanliness of the environment.

All surgical staff were required to complete mandatory training on infection control. For non-clinical staff this was completed once when starting on the surgical wards. The compliance rate for non-clinical staff on surgical wards at KCH was 80%, which met the trust’s target of 80%. Clinical staff were required to complete infection control training every two years. The compliance rate for clinical staff on surgical wards at KCH was 85.8%, which exceeded the trust’s target of 80%.
The theatre areas had a designated infection prevention and control lead who actioned any immediate concerns as well as distributing new guidance across the theatre environments when necessary.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps boxes. We observed sharps boxes were securely kept and not full in all of the surgical areas.

However, there was an issue with contaminated waste we observed on inspection. Contaminated instruments and theatre waste was wheeled through clean patient areas to a collection point. This was due to a machine being dismantled which was due to be repaired, and was not the norm.

All patients were screened on admission for meticillin resistant Staphylococcus Aureus (MRSA) and any surgical procedures or implants required three MRSA-free swabs before they would go ahead. The Day Surgery Unit had a strict policy of not admitting patients who had MRSA.

Staff highlighted concerns around inconsistency in the advice regarding patient’s infection status and their recommended care requirements. For example, previously when MRSA patients who had two negative swabs following a positive swab would be considered as MRSA free. Now any patients considered to have had MRSA previously, were now deemed to be ‘MRSA for life’ despite negative swabs. This conflicting advice confused theatre staff and they told us they felt they needed further training regarding MRSA protocols.

Cleaning trolleys were stocked with colour coded cleaning equipment in theatres and had disposable mops. Cleaning schedules were attached to each trolley and had thorough cleaning information relating to specific areas of the department.

We observed staff wearing personal protective equipment, including aprons and gloves, when delivering personal care. Gowning protocols were followed in theatres.

We observed staff adhering to hand hygiene protocols and were ‘bare below the elbow’. There were sufficient hand wash sinks and hand hygiene gels for staff, patients and visitors to use. There was signage across all surgical areas to encourage hand washing. The hand washing technique was taught by using a buddy system within theatres.

The trust undertook monthly hand hygiene audits which were mentioned regularly in handover meetings within wards. In August 2017, the audit showed all surgical wards achieved the trust’s target of 90% of compliance with hand hygiene protocols.

We observed instances in theatres where staff walked through the doors and left them open when instruments were being prepared. This posed an infection control risk as instruments were uncovered and could be affected by sources external to the theatre.

We were told by staff that there had been a rodent issue outside of the Day Surgery Unit. This had been effectively dealt with by the estates team who had ensured any access points to the hospital had been filled and ensured doors were closed. They also organised regular walkabouts and washed down external areas to remedy the problem.

Staff we spoke with told us about use of isolation rooms for infection risk patients. We observed side rooms being used, with doors shut and appropriate signage alerting staff and visitors of the infection risk. If staff had any concerns about who or how to isolate patients there was a clear isolation risk policy for them to follow.
However, some staff raised concerns that there had been some instances where they lacked rooms to use for isolation due to capacity. Staff told us whenever this had occurred they had reported this as an incident.

We saw evidence of thorough infection control audits which highlighted risks and informed staff of good and bad practice. However the trust’s audit schedule was unclear as we saw evidence of some audits being carried out monthly but we also some months were missing audits.

Environment and equipment

The majority of the ward and theatre areas we visited were well maintained, clutter-free and provided a suitable treatment environment for patients. However, the orthopaedic theatre was observed to be cluttered. The area was visibly clean and all equipment was appropriately stored but the space was not of an adequate size to hold the equipment required.

We also saw that a recovery room in the Day Surgery Unit was being used to carry out regional blocks before patients went into theatre to maximise theatre time. This space was cluttered with various pieces of equipment and therefore not wholly suitable for this procedure.

We observed in ward areas that patients stayed in single-sex bays and had appropriate access to shower and toilet facilities.

Theatres had separate anaesthetic rooms and appropriate clean and dirty areas, which were well separated.

Suitable scrub facilities were available for staff to get ready before and after theatre.

There were separate recovery areas provided and these maintained patients’ privacy.

Wards and theatres were accessible to individuals with disabilities and technical equipment was available to support individuals, where required. This included hoists, adjustable beds and bariatric chairs and commodes.

Equipment was appropriately checked and regularly cleaned and the equipment we saw had in-date safety check service stickers.

Equipment maintenance was managed by the trust’s own medical technician team and who kept maintenance logs for servicing. Staff told us that support from the maintenance team was reliable and timely.

In ward store rooms, single-use, sterile equipment was well-organised. On two occasions, we observed out of date equipment which was swiftly disposed of by management. These were isolated incidents and staff were observed checking equipment dates prior to using them.

Equipment needed for surgery was readily available and if any equipment was faulty it was replaced from the hospitals equipment store. We observed an instance where a surgeon stated an instrument was not sharp enough. Staff were quick to respond by requesting and providing a replacement.

Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit and theatre staff said there were no concerns regarding availability of the instruments for surgery or their sterilisation.

In the Day Surgery Unit, we saw evidence of staff training in using the equipment. The refresher training for equipment use was organised by Practice Development Nurses (PDNs) when required.

Emergency resuscitation equipment was available on trolleys in all surgical areas. These were checked daily by staff which was clearly documented and signed for. We observed all
consumables we checked were in-date and contents were sealed. All resuscitation treatment plans were available and up to date with the Resuscitation Council (UK) policies.

Difficult Airway Trolleys were available in all surgical areas and were checked daily by staff. This was documented and signed for. We observed that the Difficult Intubation guidelines were not up to date in one of the information folders in one of the theatres but there were up to date guidelines fixed to the machines themselves.

Medical gas cylinders in theatres were stored in line with national guidance and kept securely on metal racks. A trolley was available for transportation to be used by the dedicated medical gas porter.

**Medicines**

Medicines, including controlled drugs, were securely stored and stocks of both medicines and controlled drugs (CD) were checked daily by staff.

Controlled drugs were locked securely in cupboards and required two signatures. Only staff with the appropriate level of training had the keys for the CD cupboards.

We observed one instance where a drugs signature was not counter signed which was highlighted to a ward manager and swiftly dealt with. We observed that controlled drugs were checked and corrected regularly and accurately.

Within theatres, all controlled drugs cupboards were non-compliant with current guidance as they were not ‘double cupboards’. Staff managed this risk by always locking the outside cupboard door. The trust was aware of this issue and was due to install new cupboards in the near future.

Drug cupboards in the recovery area of theatres, not including controlled drugs, were open while the area was staffed; this was the agreed policy within the department.

Across surgical wards and theatres, we saw medicines that were required to be stored between 3°C and 9°C were stored in medicines fridges. Fridge temperatures were checked daily in most surgical areas and were maintained at recommended temperatures. However we found one instance in theatres where a fridge in the recovery area was not checked daily and did not maintain the recommended temperature. When we initially raised this, some staff did not acknowledge that this was an issue but after some discussion all drugs within the fridge were correctly disposed of and the fridge was replaced. The following day the pharmacy team were updated and had created a plan to re-enforce the correct policy with all Practice Development Nurses who were to go through these with all recovery staff. This concern was logged as an incident on the trust’s electronic system.

Medicines fridges were required to be locked when not in use. We observed these to be locked on all but one occasion, which was highlighted to and actioned by a ward manager.

We spoke to patients about their medication and looked at their medication records. Patients were given medicines in a timely way, as stated in their prescription, and records were kept accordingly.

In theatres we observed the anaesthetic medicines were kept securely with finger-print access. These were all in date and managed by the trust's pharmacy team.

We observed that medical gas cylinders were regularly replaced and there was a warning system in place to alert staff if they were almost empty.

Medication concerns, identified through audits, were discussed at the monthly trust wide Drugs and Therapeutics Committee meeting. The pharmacy team within the trust did random medicines audits and surgical staff also undertook monthly, systematic expiry date checks to ensure medications were in-date and being administered appropriately.
Records
Surgical staff used Electronic Patient Records (EPRs) and these were kept secure by using electronic smart cards for access.

We looked at 13 patient records across four wards. These were thorough, understandable and up-to-date.

Patient records included risk assessments, for example for falls, pressure ulcers and nutrition. These were regularly reassessed and updated.

Patient records showed that appropriate nursing and medical assessments were performed pre-surgery, during and post-surgery.

Patients also had bed side notes, which included appropriate observations dependent on the level of care needed for each patient.

It was mentioned by some ward staff that the mental health team could only complete patient notes if they used ward staff’s electronic smart cards as they didn’t have one. This caused delays in writing up patient notes and hindered ward staff from ward duties as they could not leave their smart cards unattended.

Staff reported concerns that it could sometimes be difficult to follow the whole patient record due to their being a mix of paper records and EPRs.

Safeguarding
Staff were able to identify abuse and describe how they reported such matters. They gave examples of when this had been necessary. Information on reporting adult and children’s safeguarding concerns was displayed in all surgical areas.

The trust’s safeguarding policy could be found on the intranet which was accessible to all staff. The policies for both adult and child safeguarding were up to date and thorough. The sections on Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE) were refreshed in February 2016.

Ward staff told us they had a good working relationship with the safeguarding team who dealt with safeguarding referrals.

Safeguarding incidents were reviewed by the safeguarding team and this information was fed-back to staff when learning was needed.

Safeguarding training completion rates – KCH
The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for Kings College Hospital is shown below:
Two of five courses have surpassed the 80% threshold by a considerable degree. The other three courses are lagging between 14-18%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training

Staff received mandatory training in several areas of practice as part of the corporate induction process and then at intervals thereafter. Subjects covered included:

- Conflict Resolution
- Equality & Diversity
- Fire
- Health & Safety
- Infection Control (Clinical & Non-Clinical)
- Information Governance
- Manual Handling (Clinical & Non-Clinical)
- Safeguarding Children Levels 1 & 2
- Safeguarding Adults Levels 1, 2, 3 & 4
- Aseptic Non Touch Technique
- Dementia
- End of Life
- Blood Transfusion
- Venous Thromboembolism
- Slips, Trips and Falls
- Security, Manual Handling, Fraud

Nurses were trained in Basic Life Support (BLS) and Paediatric Immediate Life Support (PILS) and understood their roles regarding emergency resuscitation protocols.

Mandatory training was delivered on a rolling basis and was checked by senior staff monthly. Training delivered via an e-learning service as well as face-to-face.

The trust set a target of 80% for completion of mandatory training, and it was noted several areas did not achieve the required completion target.

A breakdown of compliance for mandatory courses between June 2016 and May 2017 for the
Assessing and responding to patient risk

Staff knew how to identify and escalate risks which affected patient safety, this included bed capacity, staffing concerns and deterioration of patients health status. A National Early Warning Scores (NEWS) system was used to monitor patients, and this provided clear guidance on the process to follow for escalating to medical staff. Ward managers and matrons were easily contactable and available to address these risks.
On surgical wards, patients would generally receive 1:1 care by a health care assistant if they were at risk of self-harm, due to falls, or were at risk of absconding. If there was an indication a patient’s health was deteriorating then they would receive 1:1 care from a nurse or the iMobile team. The iMobile team was a dedicated outreach team to support ward staff with deteriorating patients. Staff told us the iMobile team was easily accessible by phone and nurses felt confident to contact them.

Senior staff we spoke with across all surgical areas were aware of the main risks affecting their specific areas and had taken steps to mitigate any risks they could.

Risks were discussed daily at handover meetings and ‘safety huddles’. We observed staff escalating when a patient’s health had deteriorated.

There was an overarching risk register for surgical wards which was used appropriately to highlight key risks and actions to be taken to mitigate these. For example, the issue of aggression and violence towards wards staff was on the risk register and included actions surrounding managing this risk.

On admission to a surgical ward or prior to surgery, patients were risk assessed and the results were included within patient records. These included risk assessments for falls, pressure ulcers and infection control risks. High risk patients were identified and placed on appropriate care pathways with the correct care plans. This ensured patients’ received the right level of care for their needs.

Access to consultants, registrars and junior doctors was available on a 24 hour basis. Staff told us, although doctors were busy, if a doctor was needed urgently they were readily available.

We observed six theatre teams undertake the ‘five steps to safer surgery’ procedures which included the WHO Surgical Safety Checklist. The WHO Surgical Safety Checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient’s care pathway and was used in any operating theatre environment.

Theatre staff did safety checks pre-, during and post-surgery and showed a strong understanding of the ‘five steps to safer surgery’ procedures. The WHO Surgical Safety Checklists we observed had good engagement from the whole surgical team, with allergies clearly stated and acknowledged by staff. All relevant information was documented in the checklists and on the theatre whiteboards. The ‘time outs’ we saw included introductions of all staff and were undisrupted. The ‘sign-ins’ we observed were clear and had engagement from all surgical staff.

Staff told us they felt the ‘five steps to safer surgery’ was being done better than previously but the ‘team brief’ remained a concern amongst staff. Recently the trust board had enforced policy to make sure all team members were present for this. This was stressful for consultants as this would cut into their ward round time. The trust had investigated this issue in the Surgical Safety Improvement Group (SSIG) monthly meeting in August 2017. They had concluded a senior presence was necessary but local arrangements could be used to determine how this was compliant in practice.

Staff carried out regular audits to monitor surgical team compliance with the WHO checklist. They did this by reviewing a random number of WHO Surgical Safety Checklists which had been completed before, during and after surgery. We saw action plans were created when concerns were found from the audits.
Anaesthetic emergency guidelines were available in each theatre, next to the anaesthetic equipment and in drugs cupboards. These were up to date and staff were aware of them.

**Nursing staffing**

Nurse staffing levels were reviewed monthly against minimum compliance standards which were based on the national NHS guidelines for staffing levels. Expected and actual staffing levels were displayed on notice boards in all surgical areas we inspected and were updated daily.

The trust and ward management monitored staffing levels using a 'flag' status. A ‘red flag’ event occurred when fewer Registered Nurses than planned were available, or when the number of staff planned was correct but patients were more acutely unwell or required a higher staffing level. Staff raised staffing concerns to ward managers and matrons. Staff told us ward management was supportive and responsive to these concerns.

Staffing data from May 2017 showed many surgical areas at KCH had been running on a ‘red flag’ status largely due to annual leave and sickness absence.

Ward staff told us the staffing levels felt “very stressful” at times but didn’t feel unsafe. At the time of inspection, we observed adequate numbers of trained nursing and support staff, with the right skill mix, to ensure patients were safe.

Theatre staffing levels reflected the professional guidance of the Association for Perioperative Practice and included surgeons, anaesthetists, theatre scrub nurses, theatre support workers and theatre recovery nurses.

Theatre staff told us the staffing levels felt safe but mentioned that sickness absence and annual leave could make staffing levels feel “stretched”. Staff told us they felt comfortable to raise concerns about staffing levels and these concerns would be appropriately acted upon by management when necessary.

In the Day Surgery Unit, there was one ward nurse vacancy which was currently unfilled and two scrub nurse vacancies which were due to be filled by November. The Katherine Monk Ward had seven registered nurse vacancies which were currently out for recruitment.

Staff told us the large turnover of staff had a negative effect on staffing figures and put a strain on surgical wards. The trust was tackling this issue by implementing a phased recruitment process of overseas staff and attractive professional plans for staff.

Matrons and ward managers checked staffing levels daily and escalated shortfalls to senior management when necessary, largely due to sickness or unplanned leave. Staff levels were maintained by using the ‘NHS Professionals’ agency and largely from existing staff working extra hours.

Matrons and managers in theatres told us they mainly used existing staff or regular agency staff who were given induction before working alone in the surgical areas. Agency staff working in theatres were given one full day induction prior to working unsupervised.

Theatre staff told us they felt the staffing in theatres was well managed and controlled. Staff told us agency staff were not regularly used and any staffing shortfalls were covered by bank staff who were well experienced and appropriately inducted into the surgical areas.

The trust had extended the hours of the emergency National Confidential Enquiry into Patient Outcome and Death (NCEPOD) list. Staffing numbers were sufficient to support this new practice.

We were told by staff on wards that permanent staff worked with temporary staff when possible.
as to ensure there was always experienced staff in the surgical areas. Agency staff were not often used but prior to starting work in the surgical services they were all given induction and mandatory training checks were carried out.

Ward matrons told us the staffing levels were dependent on patient needs, which were assessed daily. We observed patients with a higher level of need were given 1:1 care throughout the surgical wards. This could be given by health care assistants or members of the iMobile team for deteriorating patients.

Handovers between nursing staff were undertaken during shift changes in the morning and in the evening. Handovers included discussions about patient risks and also staffing concerns.

King’s College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fall below the trusts target for a whole time equivalent (WTE) staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

King's College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fall below the trusts target for a WTE staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
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<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates - KCH

Between June 2016 and May 2017 Kings College Hospital reported a vacancy rate of 23% for qualified nursing and midwifery staff. This is higher than the trust’s target vacancy rate of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates - KCH

Between June 2016 to May 2017, Kings College Hospital reported a turnover rate of 16.8% for qualified nursing and midwifery staff. This is lower than the trust’s target turnover rate of 20%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates -KCH

Between June 2016 and May 2017, Kings College Hospital reported a sickness rate of 3% for qualified nursing and midwifery staff. This is the same as the trust’s target sickness rate of 3%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

The data supplied was incomplete and included inconsistencies. Due to this analysis has not been conducted on this data pending clarification. Amended data was not available at the time of
The trust has reported their staffing numbers below for the period June 2016 to May 2017. These numbers fall below the trust's target for a WTE staffing level of 2183.09 within the medical staff arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
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<tbody>
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<td>1885.88</td>
<td>2090</td>
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Theatre and wards we inspected had an appropriate amount of medical staff with the right skill mix. This ensured patients were safe and received the correct levels of care.

As of March 2017, the trust proportion of group registrar doctors was greater than the England average (40% compared to the England average of 30%). The proportion of consultants was similar to that of the England average (47% compared to the England average of 48%). Middle-career and junior doctors were less than the England average (6% and 7%, respectively, compared to the England averages of 11% for each type).

Staffing rotas were usually maintained by existing staff or by agency and locum doctors. Staff noted in extreme circumstances consultants would step down to cover junior shifts but this had not happened for several months.

There was sufficient on-site senior house officer (SHO) cover within the surgical service at KCH.

Where locum doctors were used, the trust completed adequate recruitments checks and gave induction training to ensure the doctors knew the hospitals specific policies and procedures.

We found there was sufficient on-call consultant cover over a 24-hour period and appropriate medical cover out of normal working hours and weekends. On-call consultants were free from other clinical duties to ensure they were available when needed.

Anaesthetic cover was manned by consultants, middle-career and junior doctors. This included five consultants, who were of varying specialty, including general, obstetric, cardiac, liver, neuro surgical and paediatric surgery. This cover was also supported by four middle-career or junior doctors including a SHO and a senior theatre, an obstetric and a neuro surgical registrar. There was also ICU registrars available for cover if there was staffing issues.

We were told by staff there had previously been issues with anaesthetic cover for out of hours and weekends. This had improved by implementing a dedicated trauma list with extended hours of 8am to 6pm including weekends.

The trust has also implemented a new change to the emergency National Confidential Enquiry into Patient Outcome and Death (NCEPOD) list. The emergency NCEPOD list had changed from being led by an anaesthetic registrar to a dedicated consultant anaesthetist and also had its hours...
extended to 8am to 6pm including weekends. This allowed lists to run more efficiently with a better continuity of care.

Staff rotas ensured sufficient on-site middle-career and junior doctors across each specialty during a 24-hour period. Both theatre and ward staff told us they received good support from the consultants and ward specific doctors.

The trust has reported their staffing numbers below for the period December 2016 and May 2017. This data is not surgery-specific.

### Vacancy rates - KCH

Between June 2016 and May 2017, Kings College Hospital reported a vacancy rate of 14.5%. This is higher than the trust’s target vacancy rate of 8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

### Turnover rates - KCH

Between June 2016 and May 2017, the Kings College Hospital reported an average turnover rate of 3.5% in the medical and dental arena. This was notably lower than the trust’s target turnover rate of 20%. Of note was a spike in the monthly turnover rate in August 2016, when it was recorded as 14%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

### Sickness rates - KCH

Between June 2016 and May 2017, the Kings College Hospital reported an average sickness rate of 2.6% in the medical and dental arena. This is below the trust’s target sickness rate of 3%. The monthly rate exceeds 3% from January – March 2017.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

### Bank and locum staff usage

The data supplied was incomplete and included inconsistencies. Due to this analysis has not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)
Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at King's College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tr>
<td>Consultant</td>
<td>46%</td>
<td>48%</td>
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<tr>
<td>Middle career</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>41%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior</td>
<td>6%</td>
<td>11%</td>
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(Source: NHS Digital Workforce Statistics)

Major incident awareness and training

There was a major incident plan which identified risks that could affect the provision of care. The trust had protocols for deferring elective activity to prioritise unscheduled emergency which were set out in the plan. Staff were aware of the major incident policy within the trust and could gain easy access through the trust's 'Kwiki' intranet pages.

Staff we spoke with on wards and in theatres had a strong understanding of major incidents. They knew what actions to take if a major incident had been declared.

Staff had been affected by the recent major incidents within the London region, including the London Bridge terror attack and the fire at Grenfell Tower. Staff had used the major incident plan effectively in these instances and were offered counselling by the trust afterwards.

All anaesthetic consultants were divided into teams to allow a staged response to major incidents. A team leader was initially contacted and teams were called in as required.

Major incident training completion rates

No training data pertaining to major incident awareness or training was available at the time of production of this report.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Is the service effective?

Evidence-based care and treatment

We reviewed 16 patient records and saw patients’ care and treatment was planned and delivered in line with evidence-based guidelines.

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital’s intranet.

Staff we spoke with knew how to access these policies and local procedures. Some wards also kept hard copies of protocols so that staff were able to access these in the event of IT downtime. We reviewed a sample of trust policies for surgery and found appropriate reference to relevant NICE and Royal College guidelines. All policies we reviewed had a document owner, a date of approval and a date for review.

The hospital used the national early warning score (NEWS) to identify deteriorating patients. This was monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 ‘Acutely ill patients in Hospital.’ We saw regularly updated NEWS on patient records.

Printed copies of safety guidelines from the association of anaesthetists of Great Britain and Ireland (AAGBI) were kept in folders with a laminate attached to each anaesthetic machine. Staff were able to describe to us how they followed these guidelines appropriately.

The surgical services had care plans in line with ‘Enhanced Recovery Programme - NHS Institute for Innovation and Improvement’. Enhanced recovery is an evidence-based approach that helps people recover more quickly following major surgery. We saw there were enhanced recovery after surgery (ERAS) protocols for paediatrics dental patients; suspected infective meningitis and encephalitis and carpal tunnel syndrome. There were also ERAS protocols following hepatopancreatobiliary surgery; bariatric surgery; colorectal surgery; and hip and knee surgery.

Pain relief

Staff used a recognised tool based on a numeric rating scale to assess patients’ pain and the effectiveness of pain relief. This tool asked patients to score their pain from one to four, with one meaning no pain and four severe pains. This tool was embedded in the recovery and ward post-operative care parts of the patient record. Nurses told us if a patient’s pain score went up they were reviewed by a doctor and given pain medication. We saw results of the September pain audit for Coptcoat Ward, which had reviewed three patient records, and included patient comments. The audit identified one incomplete pain assessment. Other results confirmed that all patients who experienced moderate pain severity were given appropriate and prompt pain relief and those actions were recorded.

There was a hospital pain management team; nurses told us they referred patients with severe or uncontrollable pain to the team, whom we were told were supportive and responsive. Nurses told us patients returned to the wards from theatre with their pain well managed. Patients we spoke with told us their pain was ‘excellently managed’ and ‘well-controlled’.

An audit of the use of epidural was carried out between February and June 2017. Out of 100 cases identified as part of the audit, 77 were removed routinely, eight were removed accidentally and 15 were the result of a medical decision.
Nutrition and hydration

Staff used a five-step malnutrition universal screening tool (MUST) to identify patients who were malnourished or at risk of malnutrition. This involved weighing the patient regularly to monitor any weight changes and then allocating a score based on risk. Signs in the nurses’ station reminded staff to weigh patients on a weekly basis. We reviewed 11 records across three wards, all of which contained evidence of a nutritional risk assessment.

A recent audit of three wards showed inconsistencies with the completion of MUST. 93% of patients on one ward (Trundle) had a MUST completed with 24 hours of arriving to the ward. However, 30% of BMI was calculated incorrectly or was not recorded which suggested the MUST score was incorrect.

Other data reflected a snapshot taken on one day; findings showed 68% of patients on Lister Ward had a MUST score, with 44% of these completed within 24 hours of admission. However, only 30% of those admitted for more than one week had a MUST score completed for each week of their admission. Data for Coptcoat Ward showed 100% of patients had a MUST score, all completed within 24 hours of admission, of which 93% were calculated correctly. 100% of patients admitted for more than one week had a MUST score completed for each week of the admission.

We observed that each ward had a system in place to identify whether a patient needed additional assistance to eat and drink. Information about each patient’s nutritional requirements was communicated to staff at handover. In cases where there were concerns about a patient’s nutritional state, their daily food intake was recorded; if they needed assistance or encouragement to eat, their meal was served on a red tray and health care assistants were instructed to assist patients who required additional help.

Nurses told us they had access to dietitians who visited the wards on a regular basis. We saw notes written by dietitians on patient records; a volunteer who was assisting at lunchtime was able to tell us which patients required special diets or drinks in accordance with recommendations made by a dietitian.

Patient outcomes

The trust contributed to relevant national patient outcome audits and performance in national and local audit was presented at regular planned audit team meetings.

Between January 2016 and December 2016, patients at King’s College Hospital Denmark Hill had a lower than expected risk of readmission for non-elective admissions and a lower expected risk for elective admissions when compared to the England average.
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity
(Source: Hospital Episode Statistics)

Hip Fracture Audit

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.8% which falls within the expected range. This was above the 2015 figure of 7.3%.
The proportion of patients having surgery on the day of or day after admission was 68.6%, which did not meet the national standard of 85%. This figure was less than the rate achieved in 2015, which was 73.3%.

The perioperative surgical assessment rate was 94.8%, which did not meet the national standard of 100%. This was slightly better than the 2015 figure of 93.8%.

The proportion of patients not developing pressure ulcers was 92.3%, which fell in the worst 25% of trusts. The 2015 figure was 99.3%.

The length of stay was 30.2 days, which fell in the worst 25% of trusts. The 2015 figure was 27.2 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 70.9% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was not taken at this site.

The risk-adjusted 90-day post-operative mortality rate was 1.3%, which was within the expected range. The 2015 figure was not taken at this site.

The risk-adjusted 2-year post-operative mortality rate was 21.6%, which falls within the expected range. The 2015 figure was not taken at this site.

The risk-adjusted 30-day unplanned readmission rate was 5.2%, which falls within the expected range. The 2015 figure was not taken at this site.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 49.2%, which falls within the expected range. The 2015 figure was not taken at this site.

(Source: National Bowel Cancer Audit)

National Vascular Registry – Trust Wide

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% for Abdominal Aortic Aneurysms, indicating that the trust performed within expectations. The 2015 figure was 1.3%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 14 days, equal to the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 1.8%. The 2015 figure was 1.1%.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit – Trust Wide

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.5%. This placed the trust within the lowest 25% of all trusts for this measure.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%, significantly higher than the national aggregate.
This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit - KCH

In the 2016 National Emergency Laparotomy Audit (NELA), the King’s College hospital achieved a red (<50%) rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 82 cases.

The King’s College hospital achieved an amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 56 cases.

The King’s College hospital achieved an amber (50-79%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 51 cases.

The King’s College hospital achieved a green (>80%) rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 33 cases.

The risk-adjusted 30-day mortality for the King’s College hospital was within expectations, based on 219 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients were asked whether they felt better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 performance on groin hernias was worse than the England average. For Varicose Veins, performance was worse than the England average. For hip replacements, performance was about the same as the England average. For Knee replacements was about the same as the England average. (Source: NHS Digital)

Relative risk of readmission

Trust level

Between 01 May 2016 and 30 April 2017,

All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

Trauma & Orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Trauma & Orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions – Trust Level

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

King's College Hospital

Between 01 May 2016 and 30 April 2017,

All patients at King's College Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Neurosurgery patients at King's College Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at King's College Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Hepatobiliary & Pancreatic Surgery patients at King's College Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

All patients at King's College Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at King's College Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at King's College Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Neurosurgery patients at King's College Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - King's College Hospital**

![Elective Admissions Graph]

**Non-Elective Admissions - King's College Hospital**

![Non-Elective Admissions Graph]

**Competent staff**

Between June 2016 and May 2017, 48% of staff within Kings College Hospital had received an appraisal compared to a trust target of 90%. 161 entries within the data set have been left blank for number of appraisals carried out. This could indicate incomplete data recording of this material. It is possible this has caused the low percentage score within the site.

A split by staff group can be seen in the graph below:
The trust had an induction programme for all new staff. This included mandatory training staff needed to complete for their area of work. It also included the values and vision of the trust; aims and objectives, policies and procedures and information about health and safety.

We saw induction records for agency and bank nursing staff which confirmed their skills and competencies were checked by the nurse in charge during their induction on the first day of their shift. These staff were allocated duties only after their induction was completed.

The trust launched an online system in July 2017 (Learning Education and Appraisal Platform). This was an electronic record of all staff member’s e-learning, classroom training and appraisal records; it also included upcoming training opportunities. Managers were confident this tool would make it easier to keep track of training compliance and encourage further training.

Restructuring of specialty beds took place some weeks prior to our inspection. This meant that the patient profile on certain wards had changed. For example, one ward (Lister) was expected to take trauma patients. Staff told us trauma patients who required specialist nursing were not accepted onto the ward until nurses were competent to meet their needs. We saw that training was provided by the trauma team and the iMobile team (an intensive therapy unit team).

We spoke with staff on Coptcoat Ward which was also affected by the restructuring; they told us they were confident the staff skill mix on the ward met the changed patient profile.

Other staff said they felt well supported with regards to their development. For example, one health care assistant (HCA) told us they were encouraged to consider nurse training and were encouraged to do other courses to add to their training portfolio.

Nurse and medical staff spoke highly of audit half days, which were held each month and were a way for staff to come together in their own specialisms to discuss business, train and share learning. We saw agendas for several of these audit half days which covered a wide range of topics and usually included a presentation and a guest speaker. This time was protected to ensure maximum attendance; nursing staff from other wards covered for each other and surgical...
procedures were suspended each month to enable medical staff to attend their particular audit day.

A practice development nurse showed us examples of previous audit days for nurses. This included training on pump and syringe driver use, venous thromboembolism (VTE) and deep vein thrombosis (DVT) risk assessment and pre and post-operative care of the diabetic patient. An anaesthetic practitioner’s audit day identified future training for staff.

Current appraisal rates for nursing staff were significantly below the trust target of 90%. For example, of the six surgical wards, one recorded an appraisal rate of 13.9% with the remainder recorded between 50% and 69%. A senior nurse told us several new staff had recently joined; where possible, they had an interim appraisal at six months to ensure they were getting the appropriate experience in preparation for their annual appraisal.

Appraisal rates for medical staff were 83.1%, which was also below the trust target of 90%. It should be noted there remained a number of months for the current financial year in which appraisals could be completed.

**Multidisciplinary working**

There was an effective multidisciplinary team (MDT) working environment within the surgery service at KCH. We found evidence of good multidisciplinary relationships supporting patients’ health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.

Patient records demonstrated input from allied health professional including physiotherapy, dietitians, occupational therapists, pharmacists as well as nursing and medical teams.

Nurses reported good access to and effective support from physiotherapists, occupational therapists, the trust pharmacy team and the palliative care team. There was a daily handover on each ward between nursing staff, physiotherapists and occupational therapists.

Weekly meetings were held between nursing staff and a specialist medical team which assessed all surgical patients over 65 years old. There was also a weekly multidisciplinary long stay patients meeting which included physiotherapists, occupational therapists, performance matron, discharge coordinator and orthopaedic coordinator.

Surgical specialties held regular MDT meetings. Minutes from recent theatres and anaesthetics meetings highlighted discussions which took place including performance reports, risk register, staffing levels and referral to treatment times.

Each surgical specialty team conducted a ward round which the nurse in charge attended. In cases where they were unable to attend, then a junior doctor handed over any decisions taken or plans made for the patient.

**Seven-day services**

Since the last CQC inspection a dedicated trauma list with extended hours (8am until 6pm) including weekends was introduced. There was a dedicated consultant Anaesthetist present for these lists and staff told us this contributed to better patient care.

The trust had introduced a seven-day matron service so at weekends there was always a matron available, which improved presence of senior nursing leadership.
The IMobile team (an intensive therapy unit team) was available seven days a week 24 hours a day to assess and provide support for deteriorating patients on wards.

Speech and Language Therapists (SALT) and dietitians were available Monday to Friday.

There was a seven day CT service and a seven day interventional radiology service available to surgical services. There was no regular seven day ultrasound service due to staffing issues.

Physiotherapy services were available seven days a week by a dedicated physiotherapist’s team; an on-call physiotherapist was available out of hours.

Occupational therapists were available seven days a week. There was also access to pharmacy seven days a week and pharmacists attended patient ward rounds.

Pharmacy services were available from 09:00 – 19:00 Monday to Friday. A pharmacist visited the wards between 10:00 and 17:00 on Saturdays and 11:00 and 17:00 on Sundays. There was an on-call pharmacist outside these hours.

**Access to information**

There were information posters on the walls by ward computer workstations for staff reference. These included the trust’s unwell patient escalation protocol; daily review of patients checks, dietetic referral process, chaplaincy access, MUST assessments guidance, and sepsis identification guidance. This information was clearly displayed and easily accessible to all.

Computer stations with intranet and internet access were available on each ward for staff to use, including agency staff. Staff told us they accessed the intranet for any information and we saw copies of newsletters and safety updates sent to all staff. Monthly audit meetings were also used to disseminate information.

The King’s College Hospital public website contained a wide range of information on service provision and what each ward or surgical specialism provided.

**Health Promotion**

Staff told us they saw it as part of their responsibility to support patients to achieve the best possible results from their surgical procedure. For example, nurses and physiotherapists encouraged those patients who had hip replacements to continue with their exercise regime post discharge and they were given an exercise sheet to follow. Nurses told us they discussed with patients the ways in which smoking impacted on healing and recovery.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

The trust adult safeguarding team provided advice and support to front line staff across the site, this included assessment of mental capacity, best interest decision making, least restrictive care planning and on-going review of any Deprivation of Liberty Safeguards (DoLS).

Mental Capacity Act (MCA) and DoLS training was included in mandatory safeguarding training. Nursing staff compliance with this varied between 78% (Coptcoat Ward) and 97% (Twining Ward) where the trust target was 90%.
Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support. They were aware of the requirements of their responsibilities as set out in the MCA and DoLS, and told us they would refer patients to the trust safeguarding team if patients required a MCA referral. DoLS applications were also dealt with by the safeguarding team.

We saw patient consent was clearly documented on all records we looked at. There were separate forms for those patients who had capacity to consent and those who lacked capacity. For those patients who lacked capacity, we saw evidence of best interest discussions and decisions.

Staff we spoke with demonstrated a good understanding of capacity and told us it was always considered when supporting a patient. Patients told us how staff always asked for consent before they initiated any care or treatment.

**Mental Capacity Act and Deprivation of Liberty training completion - KCH**

The trust reported that between June 2016 and May 2017, Mental Capacity Act (MCA) training has been completed by 74% of eligible staff in within Kings College Hospital.

Data around provision of deprivation of liberty training was not provided and was not available at the time of this report.

### Is the service caring?

**Compassionate care**

We spoke with 21 patients and family members, the majority of whom were happy with the care and treatment they or their relative had received while in hospital. Direct comments from patients, which were representative of this feedback included: “staff are very caring, they always seem concerned about me,” “staff are friendly and smiley and take the time to chat with us,” “staff keep me informed of what is going on and I feel involved” “staff are so kind, lovely, caring and very respectful”, and “staff are very kind and give you their full attention.” A family member said “my [relative] hasn’t stopped saying how good all the staff are.”

We observed how a health care assistant took time to reassure an elderly patient who was unsettled by the general activity in the ward.

Patients told us staff respected their privacy and dignity. We saw staff covered patients up when they left the ward to go to theatre.

We saw many thank you cards from patients displayed around the nurses’ stations on all the wards we visited.

**Friends and Family test performance**

The Friends and Family Test response rate for Surgery at King's College Hospital NHS Foundation Trust was 36%, better than the England average of 29% between July 2016 and June 2017.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at King’s College Hospital NHS Foundation Trust, by site:**
Patients on surgery wards and those whom we spoke with in theatre told us their pre-assessment by consultant surgeons fully explained the risks and benefits of the procedure and provided information about after care and home support.

Theatre and recovery nurses told us how relatives and carers of children, patients with learning difficulties or those with specific needs were allowed into the recovery areas to help them feel...
more secure. We spoke with a patient in the Day Surgery Unit who was in a side room. They told us a nurse had suggested they wait there before seeing the consultant as they were experiencing a high level of anxiety. They told us they were very grateful for this demonstration of sensitivity to their needs.

However, we saw that on occasion, patients in main theatre were brought into the theatre area well in advance of their procedure. For example, one patient was taken in to the anaesthetic room one hour before their anaesthetic was started. This patient was elderly and was obviously unsettled by the general busyness in the anaesthetic room area. We observed a member of staff offering reassurance and providing them with updates on their estimated time to go to theatre.

Staff told us patients were often brought to theatre early as there was space for only two patients in the outside holding bay and very limited space for relatives or family friends to remain with the patient at this time.

**Emotional support**

There was a chaplaincy service at King’s College Hospital available to patients and their relatives and carers. The Chaplaincy team provided spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. There was a chapel, a quiet room and a Muslim prayer room on site. We saw information displayed about the chaplaincy service on surgical wards and in the day surgery unit.

Staff told us they referred to the psychiatric liaison service within the trust if support was needed to assess mental health needs of patients. They also told us the trust safeguarding team was very responsive when asked for advice or support about a patient.

**Is the service responsive?**

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

Data submitted by the trust showed there were 6940 day cases between June and August 2017. Of these, 202 (2.9%) stayed overnight in the main hospital. Staff told us some of the reasons for an overnight stay included slow recovery or concerns about bleeding.

Between February 2016 and January 2017 the average length of stay for surgical elective patients at King’s College Hospital was 4.1 days, compared to 3.3 days for the England average. This statistic was improved by August 2017 where the average length of stay for surgical elective patients dropped to 2.5 days, better than the England average of 3.3 days.

The average length of stay for surgical non-elective patients was 7.7 days, compared with 5.2 for the England average.

The average length of stay in trauma and orthopaedics at August 2017 was longer than the England average for both elective surgeries, 5.4 days against England average of 3.4 days and non-elective surgeries, 10.6 days against an average of 9 days.

The average length of stay for patients in recovery was three hours in the day surgery unit and two hours in main theatres. There were however, a total of 96 patients between March and August 2017 who were detained in main theatres recovery area for an average of 8.6 hours.
**Average Length of Stay – Trust-level**

1 Top 3 specialties for specific trust based on count of activity.

**SOURCE:** HES - LoS (04/04/2016 - 31/01/2017)
website: HES (Hospital Episode Statistics)

**Average Length of Stay – King’s College Hospital (Denmark Hill)**

1 Top 3 specialties for specific trust based on count of activity.
Access and flow

There was improvement in utilisation of most theatres since the last CQC inspection in March 2015, where some theatres were at 66%. Current theatre utilisation in the Day Surgery unit between March and August 2017 averaged at 77%. Average utilisation in main theatres for the same period was 80%.

A business manager told us increased productivity was due in part to the introduction of a theatre utilisation tool. We saw data produced which in addition to utilisation, also reflected cancellations and reasons for these; late starts, overruns and underruns. This information was discussed at weekly theatre stakeholder meetings. Minutes from one such meeting noted the occurrence of late starts and referred to an ‘On Time Starts’ project which had begun in the department to improve efficiencies.

Another improvement to increase productivity since the last CQC inspection in March 2017 was the introduction of the ‘8-4-2’ rule. This was where surgery for each specialty was planned eight weeks in advance and a full patient list was allocated to a theatre. The specialty had four weeks to ensure they had staff cover for this allocation; if the surgery allocation could not be covered then it was offered to another specialty. If the allocation remained unfilled, it was cancelled at two weeks prior to the booked date.

A significant change made since the last CQC inspection to improve productivity was the introduction of a dedicated trauma list with extended hours (8am until 6pm) including weekends. There was a dedicated consultant Anaesthetist present for these same lists. Medical and nursing staff spoke positively about the change this made and told us it meant theatre lists ran more effectively and efficiently, with better continuity of patient care.

We found theatres were based by procedure type, for example, general surgery and orthopaedic procedures were not included in the same session list. This minimised potential risks for cross-contamination and infection prevention and control. There were designated theatres for specialties, for example, neuro surgery, cardiac and liver procedures; other theatres were designated for out of hours or paediatric surgery.

The maximum waiting time for non-urgent consultant-led treatments was 18 weeks from the day an appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter. We noted that the specialties with the highest patient numbers at July 2017 included Trauma & Orthopaedics (2893), Ophthalmology (2236) and Gynaecology (2034). The lowest included Cardiothoracic Surgery (207), Hepatobiliary & Pancreatic Surgery (245), Pain Management (55) and Plastic Surgery (41).

The trust’s referral to treatment time (RTT) for admitted pathways for surgery between June 2016 and May 2017 was 63% and dropped to 53% at May 2017. It underperformed against the England average for the entire reporting period.
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, one specialty was above the England average and four of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>76%</td>
<td>67%</td>
</tr>
<tr>
<td>ENT</td>
<td>41%</td>
<td>66%</td>
</tr>
<tr>
<td>Urology</td>
<td>61%</td>
<td>78%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>39%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Percentage of patients whose operation was cancelled and were not treated within 28 days

Over the two years the percentage of cancelled operations at the trust showed an upward trend, and was generally higher than the England average. The trend followed the expected spike in Q4 2016/17 (winter time) as per the England average. There was a notable drop after this spike. At this point the trusts performance mimics the curve of the England average, although performs below it for the rest of the reporting period.

(Source: NHS England)
If a patient has not been treated within 28 days of a last-minute cancellation then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

There were 45 on the day cancellations out of a total of 9526 (0.47%) surgical procedures between June and August 2017. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation.

There were 14 unplanned readmissions for this same period, 10 of which were emergency and eight of whom were readmitted within one day of surgery. Reasons for readmission included manipulation of shoulders and hips and changes of dressings.

The trust patient discharge policy states that discharges after 21:00 should not occur, unless it is patient choice. Out of Hour Discharges (20:00-08:00) represented 8% of all surgical discharges between June and August 2017.

Outliers are patients who were under the care of a surgery service consultant but looked after on a different ward. There was a total of 657 outliers on non-surgical wards between June and August 2017 which represented a total of 6.2% of surgical bed days.

**Meeting people’s individual needs**

There was no separate paediatric holding bay in theatre and children went into a two bedded bay which could be shared with an adult. They were accompanied by a paediatric nurse at all times. There was a paediatric recovery area staffed by paediatric trained nurses.

We saw booklets on wards which gave patients information on the care they could expect, as well as general information about the ward.

Patients said staff were knowledgeable and able to answer any questions they had. In addition, we saw copies of post-operative information which included wound care, symptoms of possible infection and telephone numbers of the ward to ring for advice.

There was a dementia and delirium team service who provided bedside treatment and care for patients admitted with dementia and delirium. Some wards had activity boxes to support with therapeutic engagement, stimulation and activity.

There was a ‘Forget-Me-Not’ programme to provide additional support to patients living with dementia. All patients admitted with dementia and those with communication or comprehension needs were offered a ‘this is me’ document to be completed as part of a personalised care plan. This document captured information about the patient’s personal preferences to allow their care to be responsive to their needs.

Patients with a learning difficulty were flagged on the electronic patient record. This flag gave general advice and reminded staff to consider the mental capacity act and any reasonable adjustments they needed to make to ensure a good experience for the patient. All patients with a learning difficulty were notified to the safeguarding team; in addition, there was a learning disability nurse specialist who reviewed each patient and referred to community learning disability services as appropriate. One ward we visited where there was a patient with a learning difficulty had engaged the support of a speech and language therapist to assist with communication. Staff were already using a communication board which assisted with simple instructions and words.
Staff said patient information was available in different formats or languages as required. Patients were advised to contact the Patient Advice Liaison Service (PALs) if they required information leaflets in a language other than English.

Staff were able to access interpreter services for patients whose first language was not English. Staff could book interpreters for face to face meetings or over the phone.

The patient feedback forms were available in other languages and easy read versions for people with communication difficulties. Staff told us they could access Speech and Language Therapy (SALT) for patients with learning difficulties or communication impairment.

There were regular protected meal times on surgical wards and we saw these were respected by staff and visitors. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary. The hospital also had a number of volunteers who helped patients with eating. Patients told us nurses ensured they were kept well hydrated. Hot and cold drinks were provided throughout the day. We saw a card on display (fluid balance flash card) at nurse’s stations to remind staff of the importance of fluid balance monitoring.

Most patients we spoke to were happy with their food choices on the wards, and said there was much to choose from. We reviewed patient menus and saw a range of options for specialist diets including vegetarian, gluten free and softer options.

Staff told us they referred to the psychiatric liaison team where they had concerns about the mental health of a patient. They also said the training provided on de-escalation, challenging behaviour and mental health in the acute setting enhanced their ability to support patients. Health Care support workers were trained on the absconding patient, dealing with challenging behaviour and mental health currently as part of their induction.

**Learning from complaints and concerns**

**Summary of complaints - KCH**

Between June 2016 and June 2017 there were 650 complaints about services at the Kings College hospital. The trust took an average of 94 days to investigate and close complaints; this is not in line with their complaints policy, which states complaints should be resolved within 25 days.

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

There were 87 complaints between June 2017 and September 2017 in surgical services. Of these, 21 related to orthopaedics, 18 to general surgery and 12 each to ophthalmology and colorectal. The main themes from these complaints were related to clinical treatment (28), appointments including delays and cancellations (13) and communication (13).

There was a Patient Liaison Service available to patients and we saw information leaflets in all of the areas we inspected.

Clinical and nursing staff told us they tried to resolve any complaints as soon as possible with the patient or their relatives. If this was unsuccessful, the matter was escalated to a senior member of staff. Ward managers told us they provided feedback to staff about complaints at monthly staff meetings.
Is the service well-led?

Leadership

A new structure of leadership was introduced to the surgical services in December 2016. This included a director of nursing, a divisional medical director and a deputy director of operations. We interviewed the director of nursing, medical director and deputy director of operations during the course of this inspection.

They told us that whilst the management structure was still relatively new, much progress had been made with regards to staff engagement. They said one priority was for staff to know who their managers were and to bridge the gap between management and staff that had existed previously. Other priorities included good engagement with medical staff which would help to increase theatre utilisation; strong governance strategy, and the development of clinical leadership across the different surgical divisions.

Members of the leadership team told us they placed a high level of importance on staff engagement at all levels and the sharing of information. One way in which they did this was to have a meeting agenda for all meetings which included standardised items to ensure the same information was being shared. There was also a series of ‘board to floor’ engagement meetings run by the leadership time for healthcare assistants and bands 5 and 6 nurses.

Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons, who were visible and approachable. Most staff were aware of the local senior management structural changes and were able to tell us who the senior leads for the service were. Many told us they felt they were listened to and could contribute to driving up standards at King’s College Hospital.

Surgical services were represented at trust board level by the chief nurse, medical director and chief Operating Officer. The Board received regular updates on safety and quality from the front-line at the Quality, Assurance and Research Committee. The Patient Safety team, Patient Experience team and Patient Outcome team provide reports with updates on issues and achievements from the different specialities.

Vision and Strategy

In April 2016, King’s College Hospital NHS Foundation Trust developed its “BEST” strategy (Best quality care; Excellent teaching and research; Skilled “can do” teams and Top productivity) where patients come first and receive the best care and services. The trust aimed to be an outstanding local hospital at the heart of the communities it served and a world-class centre for specialist clinical, teaching and research excellence.

Most staff were aware of the BEST strategy and told us they were committed to delivering good quality care. We found that staff had a strong sense of identity with the local community and were proud of the service which King’s College hospital Denmark Hill provided.
Culture

We found, for the most part, an inclusive and constructive working culture within the surgery service. Staff we spoke with felt that King’s College hospital was a good place to work. Nurses and doctors reported approachable and supportive colleagues and described the working environment as made up of a happy staff group with supportive managers.

Many described the culture and morale as hugely different since the time of the last CQC inspection in March 2015. They attributed this to initiatives which included the King’s commendation. This was a trust award for the delivery of good quality care. We visited Kinner Wilson ward which had won a commendation some months before and staff told us how it boosted their morale to know their commitment to quality service delivery was recognised. On another ward, a matron spoke with passion about their aim to win a commendation based on initiatives they had introduced to the more efficient working of the ward.

Some staff described to us how they were encouraged to undertake further training to enhance their roles. A health care assistant told us they were considering pursuing a career in nursing as a result of encouragement from a ward matron. Nurse told us they had additional skills training since the recent restructuring of wards, particularly in relation to trauma nursing.

Governance

Clinical governance structures were in place across the surgery service lines and staff felt they were effective.

The surgical quality and risk committee meeting met on a monthly basis. This included a patient safety manager, director of nursing, medical consultants and representatives from surgical wards. We looked at minutes from four previous meetings and saw there was a good attendance rate. Any new risks to the register were discussed, with action plans and tasks assigned to individuals. On-going risks were updated and closed as necessary.

There was a Surgical Safety Improvement Group meeting held each month. This was chaired by the corporate medical director and included the patient safety manager, patient safety and governance officer and the general manager theatres and anaesthetics. Also in attendance was the head of nursing for surgical service and a range of consultants, matrons and practice development nurses from different specialisms.

A wide range of topics was discussed and included compliance with the World Health Organisation 5 steps to safer surgery, surgical count statement of purpose (in response to a Never Event) and agreement for a standardised induction and competency check for nursing staff.

The trust disseminated feedback from serious incidents to all staff in a newsletter (SafetyNet) which included shared learning and any resultant changes to policies and procedures.

Management of risk, issues and performance

Surgical services maintained a risk register which had 31 current risks on it; of which 12 were rated as high. The risks with the highest score (out of 20) included the lack of comprehensive orthoplastics service (Orthopaedics) on site at King’s Major Trauma Centre. This meant a delay in treatment as patients were transferred to another hospital. Actions to manage this included
the development of a business plan for more staff and reallocation of theatre space.

Two further risks rated as high (Anaesthetics and pain) were outdated anaesthetic equipment and failure of the anaesthetic IT system. High risks for theatre included lack of capacity for emergency orthopaedic trauma cases, especially out of hours. Another identified high risk related to insufficient consent, including failure to perform a two stage consent process; the outcomes attributed to this were surgical errors, poor patient experience and outcomes. We saw this was a topic of discussion at the February meeting of the surgical quality and risk committee.

**Information Management**

Information technology systems were used effectively to monitor and improve the quality of care. The trust recently introduced a telephone application based method of audit. This was a quicker way in which to audit performance in all areas. It stored all quality and safety inspections which made it easy to see arising problem areas. A matron told us they could address any deteriorating areas quickly and so maintain safety.

**Public and Staff Engagement**

There were no formal public consultations in 2016-17. The trust had a number of ways in which to engage members of the public, amongst which was the ‘How are we doing?’ surveys. Patients and relatives were encouraged to complete comment cards. The most recent analysis of those which related to surgical services were positive about staff friendliness, helpfulness and professionalism.

Patient governors were involved in a range of committees including patient experience, safety and membership and community, public health, staff commendation and end of life care. They visited areas of the hospital on a regular basis to speak with patients, observe patient dignity and carry out food audits.

Patient governors met with King’s members and patients in different ways such as Health Talks, community meetings and the Annual Members meeting.

There was engagement with a range of voluntary organisations including Macmillan London, Alzheimer’s Society, local community umbrella organisations and specific community groups. There was a volunteer programme which included 700 volunteers, many of whom provided direct patient support.

The 2016 NHS staff survey results for the trust were based on a 90 question, on-line survey open to all staff employed by the trust. Staff were surveyed between mid-September and beginning of December 2016. The trust was in the worst 20% of all trusts for 17 measures in the staff survey.

The percentage of white staff which thought the organisation provided equal opportunities for career progression or promotion was 84% compared with 82% in 2015, where the national average for NHS trusts in 2016 was 88%. Results for black and minority ethnic (BAME) staff was 65%, a drop from 76% in 2015, with a national average for NHS trusts in 2016 of 87%. The percentage of staff who reported good communication between senior management and staff dropped to 25% from 34% in 2015.

The trust outlined some of the actions taken in response to the 2016 staff survey. Six staff engagement work streams were established, each led by a member of King’s Executive. One
focused on diversity and inclusion and another focused on the role of line managers and how they could best support their staff. A trust wide BAME network was launched in July and September 2017 and a ‘reverse mentoring’ programme was being set up, where member of staff from of a BAME background mentored a senior leader.

The trust were also appointing 12 Freedom to Speak Up Guardians whose role it was to support staff to raise concerns and fears around bullying, harassment and discrimination at work. We saw posters on public display which publicised this new role and most staff we spoke with knew about it and how it could be used.

Innovation, improvement and sustainability

A surgical assessment unit (SAU) opened three weeks prior to this inspection. This service was expected to relieve pressure on the emergency department by taking patients from there for specialist treatment within the SAU. The length of stay for these patients would not exceed 24 hours.

The trust introduced the ‘Perfect Ward’ telephone application (app) based tool that recorded data via a handheld device. Matrons we spoke with were very enthusiastic about this tool, which replaced paper based methods of monitoring quality and safety. The Perfect Ward app stored all quality and safety inspections and allowed staff to complete and report on them in a very short timescale.

There was a new initiative (King’s Way for Wards) to standardise the way teams work across the trust in order to foster a culture of continuous improvement and problem solving.

SafetyNet was a trust-wide initiative which was launched in June 2017. This was a newsletter in which information and learning from incidents was shared. Most staff we spoke with found it to be a useful way to learn from incidents. We saw copies of it on display on staff noticeboards.
Facts and data about this service

The trust has 69 Critical Care beds at Kings College Hospital. These beds are split across four critical care wards within the hospital, as shown in the table below:

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack Steinberg Critical Care Unit</td>
<td>18</td>
</tr>
<tr>
<td>Frank Stansil Critical Care Unit</td>
<td>14</td>
</tr>
<tr>
<td>Christine Brown Critical Care Unit</td>
<td>18</td>
</tr>
<tr>
<td>Liver Intensive Therapy Unit (LITU)</td>
<td>15</td>
</tr>
<tr>
<td>Liver HDU (attached to the LITU)</td>
<td>4</td>
</tr>
</tbody>
</table>

In addition, there are high dependency units (HDUs) within Kinnier Wilson Ward (a neurosurgical ward treating patients with brain and spinal injuries); and Victoria and Albert Ward (a cardiac ward). The HDUs are managed under the respective operational care group management teams and within the divisional governance structure of the lead division, Networked Care.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinnier Wilson HDU (Neuro HDU)</td>
<td>11</td>
</tr>
<tr>
<td>Victoria and Albert HDU (Cardiac HDU)</td>
<td>10</td>
</tr>
</tbody>
</table>

Over 3000 patients a year are admitted to the critical care unit. The hospital is also a tertiary service for transplants as well as well as trauma.

During our inspection, we spoke with 29 members of staff including consultants, doctors, nurses, allied health staff and domestic staff. We spoke to 16 patients and a number of their relatives who were using the service at the time of our inspection. We observed care and treatment and looked at 16 patient records and medication charts.

Is the service safe?

Incidents

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between August 2016 and September 2017, the trust reported no incidents classified as never events for the Critical Care Unit (CCU).

Staff reported 492 incidents in Critical Care between May 2017 and August 2017. Each incident was classified according to the severity of the incident. Two were classified as “major injury”, 108 as “minor injuries or illnesses”, two as a “moderate injuries or illnesses”, 300 as “no harm” and 80 as “prevented or avoided harm”.

In accordance with the Serious Incident Framework 2015, seven serious incidents (SIs) which met the reporting criteria set by NHS England were reported between 1 July 2016 and 30 June 2017 for Critical Care.

Of these, the most common types of incident reported were
- Surgical/invasive procedure incident meeting SI criteria with three (43% of total incidents).
- Pressure ulcer meeting SI criteria with one (14% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (14% of total incidents).
- VTE meeting SI criteria with one (14% of total incidents).
- Slips/trips/falls meeting SI criteria with one (14% of total incidents).

Following the inspection, the trust informed us two of the serious incidents were downgraded.

We reviewed RCA reports for two of the serious incidents and found appropriate investigations had taken place. We found the trust had identified the root causes, analysed the contributing factors to the incident and identified actions to reduce the risk of similar incidents occurring in the future.

For example, an incident occurred in which a patient suffered radial and ulnar occlusion. Information had been communicated to all medical staff highlighting the importance of prompt referral to vascular surgical team for review of all patients where circulatory problems may be expected. Individual staff reflections were completed and there was a discussion with vascular laboratory staff on the need to arrange investigations promptly.

Staff at all levels in Critical Care were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit. Learnings from incidents were shared during handovers, team meetings, on staff notice boards and via emails. Staff understood their responsibility under the duty of candour regulations and we saw examples of the correct process being followed from our review of the incidents.

We reviewed the notes of mortality and morbidity (M&M) meetings in the last three months before our inspection and found that they were informed by a deceased patient summary. Minutes of the M&M meetings indicated that areas of learning were identified and actions from the meetings were specified. For example, during an M&M meeting on 22 August 2017, staff concluded in one case it was unlikely that the death would have been avoidable. However, they felt an earlier and clearer communication with the family in relation to the high-risk nature of the procedure might have been better accomplished.

(Source: Strategic Executive Information System (STEIS), Additional data request DR124, DR125, DR126, DR139, and DR142)
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Information received from the trust indicated this method of collecting patient safety related data was no longer used. In its place, the trust was using a ‘Perfect Wards’ system. This was a weekly audit looking at a range of indicators such as infection, prevention and control (IPC); staffing; falls and pressure ulcers.

The CCU displayed clear, easy to read “safety data” for staff, patients and visitors on all critical care wards. It showed that between May and July 2017, there were six incidents of hospital acquired pressure ulcers reported on Jack Steinberg CCU. There were no incidents of falls reported.

During the same period, Christine Brown CCU reported one patient fall and 23 incidents of hospital acquired pressure ulcers. Frank Stansil CCU reported 10 incidents of hospital acquired pressure ulcers. There were no incidents of falls on Frank Stansil CCU during the period. The safety data on the Liver Intensive Therapy Unit (LITU) indicated there were five incidents of hospital acquired pressure ulcers. During the same period, there were no incidents of falls reported on LITU.

Information displayed on Kinnier Wilson High Dependency Unit (HDU) showed that there were no separate safety data for Victoria Albert HDU apart from the data displayed for the main ward.

Our review of patients’ notes showed that all patients had their level of risk assessed for venous thromboembolism (VTE), falls and pressure ulcers. Staff reviewed this at regular intervals. Staff informed us patients with pressure ulcers were reviewed by tissue viability nurses and we saw their input within the patient notes reviewed.

The table below shows the CCU assessment rate for VTE between February 2017 and July 2017:

<table>
<thead>
<tr>
<th>VTE</th>
<th>% of all admitted patients with VTE assessment completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feb-17</td>
</tr>
<tr>
<td>Christine Brown CCU</td>
<td>96.3</td>
</tr>
<tr>
<td>Frank Stansil CCU</td>
<td>100</td>
</tr>
<tr>
<td>Jack Steinberg CCU</td>
<td>100</td>
</tr>
<tr>
<td>LITU</td>
<td>100</td>
</tr>
</tbody>
</table>

The CCU also carried out monthly urinary catheter audits. We were provided with results for Frank Stansil CCU and Jack Steinberg CCU in August 2017. Results for Jack Steinberg CCU showed all patients reviewed had their catheter documented on the electronic patient record (EPR), all patients had their urometer (a piece of equipment used to measure urine output) bags dated, and changed after 14 days, and all had a catheter securing device in place. Results for Frank Stansil
CCU during the same month showed that 92% of 12 patients reviewed had urinary catheter devices recorded correctly on the EPR.

(Source: DR122)

Cleanliness, infection control and hygiene

The CCUs and HDUs visited were visibly clean. Other areas within the wards, such as the relatives waiting area, quiet room, toilets, the sluice room and nursing stations were clean and tidy. Patients and relatives were satisfied with the level of cleanliness on the wards.

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment, (PPE) such as gloves and aprons, and management of the spillage of body fluids.

There was easy access to PPE. Aprons and gloves were available in all areas we inspected and we observed most staff using PPE as required. There was also sufficient access to handwashing and drying facilities. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. We observed bed space curtains were labelled and dated when they were last changed.

Staff were ‘bare below the elbow’ and most staff adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients. However, we observed a few incidents where one staff on Jack Steinberg CCU did not adhere to infection control precautions, as they were not using appropriate PPE. We flagged this up with senior staff on duty, and they addressed our concerns.

Where patients had a known or suspected infection, they were nursed in single side rooms. There were three side rooms on Christine Brown CCU and two side rooms on each of the other critical care units. The liver HDU had one side room and there were two side rooms on each of Victoria and Albert HDU and Kinnier Wilson HDU. We observed that the two side rooms on Jack Steinberg CCU had systems to control airflow within the rooms.

Each side room in use had signs displaying presence of infection, which meant staff, and visitors were aware of the precautions to take prior to entering the patient area. We observed most staff adhering to these protocols and doors remained closed to these areas. We saw there were leaflets available for patients about infection control and isolation. These provided details about the purpose of isolation and what was required. However, we observed a brief period when the two isolation units on Jack Steinberg CCU were left opened.

The LITU consisted of 14 individual bed spaces and one side room. There was a risk of cross contamination, as nine of the individual bed spaces had no clinical hand wash basin. The CCU mitigated this risk by ensuring alcohol disinfectants were available by each bed space.

There were housekeeping staff for cleaning wards and cleaning staff understood cleaning frequency and standards. Green ‘I am clean’ stickers were used to identify which equipment staff had cleaned and were ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned.
Waste management, including those for contaminated and hazardous waste was generally in line with national standards. However, we noted that a room for disposing waste (including clinical waste) on Christine Brown CCU had keypad access but was unlocked.

Needle sharp bins were available throughout critical care units. All bins we inspected were correctly labelled and none were filled above the maximum fill line.

There were infection control link nurses in each of the critical care units. Microbiology and infection control staff conducted clinical rounds daily.

The CCU audited compliance with cleaning and hand hygiene guidelines every month. Between May 2017 and July 2017, the CCU achieved an overall score of 97% for compliance with cleaning standards. During the same period, staff compliance with hand hygiene standards was 95%. The table below provides a breakdown of cleanliness and hand hygiene scores across the four critical care units.

<table>
<thead>
<tr>
<th>Audit</th>
<th>Christine Brown CCU</th>
<th>Frank Stansil CCU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-17</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Cleaning audit</td>
<td>97.73%</td>
<td>98.50%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>92.27%</td>
<td>95.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit</th>
<th>Jack Steinberg CCU</th>
<th>LITU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-17</td>
<td>Jun-17</td>
</tr>
<tr>
<td>Cleaning audit</td>
<td>99.38%</td>
<td>99.70%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>99.13%</td>
<td>90.80%</td>
</tr>
</tbody>
</table>

Overall, 95% of nursing staff had completed the infection prevention and control (IPC) training across the critical care unit. This was higher than the trust’s target of 85% for mandatory training. However, we noted that the completion rate (82%) on the LITU was lower than the CCU average and the trust’s target.

Sixty-two per cent of medical staff had completed the infection prevention and control (IPC) training against the trust’s target of 85%.

Between May and July 2017, the CCU reported 10 incidents of Clostridium difficile (C.diff) infection. Of these, five where reported on Christine Brown CCU, three on Frank Stansil CCU and two on Jack Steinberg CCU. There was one incident of MRSA reported during the same period. This was reported on Jack Steinberg CCU.

(Source – DR 127)

**Environment and equipment**

Bed spaces on the CCU did not comply with the Department of Health’s Health Building note HBN 04-02, which sets out a minimum standard of space for effective infection control. In particular, we found very limited spacing between beds at Jack Steinberg CCU.
There was limited storage space on the units and we found equipment kept on corridors across critical care units. In particular, we found equipment blocked the emergency exit on LITU. We raised this with senior staff and they informed us they had risked assessed space constraints issues on the units and tried to keep it as clear as possible. Senior staff informed us they mitigated these issues by implementing good cleaning standards, robust Aseptic Non Touch Technique (ANTT) infection control standards and hand hygiene standards.

The trust informed us measures were taken locally to mitigate risks through guidance from the Director of Infection Prevention and Control (DIPC) and IPC leads. This issue was recorded on the CCU risk register and mitigating plans were in place. These included monitoring compliance with IPC guidelines, and monitoring infection rates to ensure prompt identification of any problems including daily ward round with microbiologist. They also mitigated risks by monitoring invasive lines and wounds on daily ward round and changing these as appropriate.

The trust had implemented plans to open the first phase of a new 60-bedded critical care unit by early summer 2018.

Staff maintained a reliable and documented programme of equipment checks. Nursing staff on all units had maintained resuscitation equipment with daily documented checks. We observed resuscitation equipment was readily available on the units. We found that the resuscitation trolley and difficult airway trolley was regularly checked and compliant with the Resuscitation Council guidelines. However, there were gaps in checks for one resuscitation trolley on Frank Stansil CCU. For example, there was no record for 9 August 2017. In addition, checklists for 11, 12 and 30 August 2017 had been ticked but there were no signatures to confirm who undertook the checks.

Difficult airway and emergency tracheostomy equipment was available on all the critical care units.

The CCU risk register indicated there was a lack of ultrasound machines across the units. The lack of ultrasound machines could sometimes cause delays with diagnostic procedures and other interventions. A business case had been produced in order to procure new machines.

Staff reported good access to technical support when there were problems with equipment. The team offered routine maintenance of equipment and carried out repairs when necessary. Equipment inspected had maintenance stickers showing they had been serviced in the last year.

Medicines

Medicines on all critical care units and HDUs were stored in a secure clinical/pharmacy room with swipe card/key pad access. Medicines cupboards on the four critical care units were unlocked for ease of access. This had been risk assessed and access to the clinical room was restricted via keypad combination lock. In addition, risk register indicates the new CCU will have a modern secure storage system for all medications.

A temperature checking system was in place for refrigerated medicines and fridge temperatures were monitored daily. We observed there were no gaps in daily fridge temperatures checks in three of the critical care units and two of the two HDUs reviewed. However, there were gaps in fridge temperature checks on LITU. In particular, there were no records for 1 - 4, 8, 16, and 17, the 23-25, and 28 August 2017. There were no records for the 2 and 3 September 2017. Staff said the gaps reflected the busy shift and acuity of patients on those days.

We checked a random sample of medication across the CCU and HDUs, all medication were in date.

We reviewed 16 patient records which included medication administration records (MAR) and saw they were accurately completed and signed by staff. In addition, staff documented reasons for any
missed doses. Staff appropriately documented allergies and medicines reconciliations. A pharmacist verified and documented additional administration instruction.

An electronic recording system was in place on Christine Brown CCU, Frank Stansil CCU and Kinnier Wilson HDU. We observed the system had prompts in place highlighting drugs that were given at normal intervals (during drug rounds), drugs given every two hours or at specific intervals, as required and one dose drugs.

The CCU had a dedicated pharmacy team consisting of a 5.05 whole time equivalent (WTE) pharmacists, a pharmacy technician and pharmacy assistant. A pharmacist attended a daily review of each patient and reviewed each patient’s medications to ensure that they were suitable and within prescribing guidelines. Staff reported good support from the pharmacy team and pharmacists attended multidisciplinary team meetings. There were dedicated pharmacists covering the HDUs.

The trust conducted quarterly controlled drugs (CD) audit to ensure staff adhered to set standards. The standards included the following requirements; “keys to be kept securely”, “full details at the top of each CD register page”, “stock levels tally with CD book”, “balance carried forward is recorded”, “each entry is complete”, “errors not obliterated and countersigned”, “unwanted/expired CDs returned correctly”, “storage of CD record books secure”, and “authorised person has ordered the CDs”. Each department’s compliance with CD audit was highlighted in green for 100%, amber for 90-99%, and red for 89% and below.

Results for the first quarter of 2017/18 were provided for Frank Stansil CCU, Christine Brown CCU, Jack Steinberg CCU and Kinnier Wilson HDU. Frank Stansil CCU was compliant with all standards except one. It was rated red for “authorised person has ordered the CDs”.

Jack Steinberg was compliant with six of the nine standards. However, it was rated red for “keys to be kept securely”, balance carried forward is recorded” and “authorised person has ordered the CDs”.

Christine Brown CCU was compliant with seven of the standards. However, it was rated red for “storage of CD record books secure” and “authorise person has ordered the CDs”.

The LITU was compliant with seven of the standards. However, it was rated red for “unwanted/expired CDs returned correctly” and “authorised person has ordered the CDs”.

Kinner Wilson HDU was compliant with six standards. However, it was rated amber for “full details at the top of each CD register page”. It was rated red for “unwanted/expired CDs returned correctly” and “authorised person has ordered CDs”.

Victoria and Albert HDU was compliant with four standards. They were rated amber for “stock levels tally with CD book” and rated red for “full details at the top of each CD register page”, “errors not obliterated and countersigned”, “unwanted/expired CDs returned correctly” and “authorised person has ordered the CDs”.

Following the inspection, the trust informed us all CCUs had submitted a list of authorised signatories for CDs to the pharmacy. Each unit checked the CDs after each shift to ensure all standards were met and documentation was complete and accurate. They informed us all areas were now fully compliant.

Medication training records for nursing staff showed that 98% of CCU staff had completed the training.

(Sources: DR52, DR53, DR131, DR394)
Records

We looked at a random sample of 16 patient notes across the Critical Care Units and HDUs. An electronic record system was on place on Christine Brown CCU, Frank Stansil CCU and Kinner Wilson HDU. There were plans to implement the electronic system on LITU and Jack Steinberg CCU by the end of the year. All the records we looked at included details of allergies, a daily treatment plan, and record of daily consultant reviews.

Staff recorded specialist assessments, including assessments for nutrition, neurology and respiratory needs. The records showed input from multidisciplinary team including physiotherapists, dietitian and tissue viability team. In addition, the records demonstrated consultants reviewed patients on admission to the unit and that daily consultant led ward rounds took place. All medical and nursing notes reviewed were completed, dated and signed.

Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protected systems in Kinnier Wilson HDU and Christine Brown CCU.

Staff on Kinnier Wilson HDU informed us some patients were admitted with paper notes from some of the CCUs or other hospitals. They then transcribed all information unto the electronic system. We reviewed electronic notes, which showed that staff recorded details of patient medical history and a summary of the events leading to their admission.

Safeguarding

Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Our review of patient notes showed that staff completed psychosocial assessments with prompts to identify any safeguarding concerns. Staff escalated safeguarding incidents to the safeguarding team. Staff said the team members were visible and approachable. They could also report safeguarding incidents using an electronic system. Each unit had a social worker to refer to if there was a safeguarding concern.

The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for King College Hospital is shown below:
Mandatory training

The Critical Care Unit had a dedicated practice development and education team. A practice development nurse (PDN) was attached to each ward.

Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice. Staff confirmed they received reminders from PDNs when due for an update. Staff also have access to their training records which was colour coded to highlight upcoming training.

A breakdown of compliance with mandatory training on the critical care units including Christine Brown Critical Care Unit (CBCCU), Frank Stansil Critical Care Unit (FSCCU), Jack Steinberg Critical Care Unit (JSCCU), Liver intensive therapy unit (LITU) and the critical care outreach team (iMobile) is shown below:

**Nursing Staff:**

<table>
<thead>
<tr>
<th></th>
<th>ANTT</th>
<th>Blood</th>
<th>Conflict resolution</th>
<th>Dementia</th>
<th>EoL</th>
<th>Equality &amp; diversity</th>
<th>Fire</th>
<th>Infection Control</th>
<th>Information Governance</th>
<th>MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCCU</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>no data</td>
<td>99%</td>
<td>98%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>FSCCU</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>no data</td>
<td>98%</td>
<td>97%</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>JSCCU</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>no data</td>
<td>99%</td>
<td>98%</td>
<td>84%</td>
<td>94%</td>
</tr>
<tr>
<td>LITU</td>
<td>100%</td>
<td>98%</td>
<td>80%</td>
<td>no data</td>
<td>100%</td>
<td>98%</td>
<td>93%</td>
<td>82%</td>
<td>73%</td>
<td>93%</td>
</tr>
<tr>
<td>iMobile</td>
<td>100%</td>
<td>99%</td>
<td>64%</td>
<td>99%</td>
<td>100%</td>
<td>no data</td>
<td>93%</td>
<td>100%</td>
<td>86%</td>
<td>86%</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P18)

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Nursing staff exceeded the trust’s target of 80% for most mandatory training modules with the exception of information governance for LITU staff (73%) and conflict resolution for iMobile staff (64%).

Mandatory training for all medical staff:

<table>
<thead>
<tr>
<th></th>
<th>ANTT</th>
<th>Blood</th>
<th>Equality &amp; diversity</th>
<th>Fire</th>
<th>Health and safety</th>
<th>Infection Control</th>
<th>Information governance</th>
<th>Mental health</th>
<th>Resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% compliance</td>
<td>100</td>
<td>91.3</td>
<td>81.4</td>
<td>69.77</td>
<td>77.91</td>
<td>62.79</td>
<td>45.35</td>
<td>83.72</td>
<td>47.44</td>
</tr>
</tbody>
</table>

Completion rates for medical staff were below the trust’s target of 80% for seven of 12 mandatory training modules as shown in the table above. Information received from the trust indicated that the resuscitation training record was not reflective of advance life support (ALS) course statistics. In addition, they were still awaiting an update in relation to the latest safeguarding training for medical staff.

(Source: Additional data request – Statutory and Mandatory Training)

Assessing and responding to patient risk

The critical care outreach service (iMobile) was a consultant led service providing 24 hours, seven days a week response to deteriorating patients. The team included senior anaesthetic registrars, registrars, and critical care nurses. Two critical care speciality registrars/fellows and two critical care nurses were available 24 hours a day, seven days a week. The team provided rapid response, stabilisation and transfer for patients needing immediate attention and transfer. It also provided discharge follow up for patients discharged from critical care. Outreach advice and education was also provided for patients who were acutely ill but not yet needing admission. It provided mobile critical care interventions for patient at ward beds.

There was an iMobile escalation protocol, which set out algorithms for escalating patients to the team. Staff used the early warning score to identify patients whose condition was deteriorating.
iMobile staff were alerted and were able to monitor if patients were deteriorating to the level that they needed to review their treatment. All the staff we spoke with praised the iMobile service. They particularly supported the HDUs for patients that were stepped down from the CCUs or patients at high risk of deteriorating. Any patient potentially needing escalation of care required a review by iMobile first.

There was an iMobile link nurse on every ward thereby helping to develop earlier intervention in deteriorating patients. Our review of staff survey results in relation to iMobile activities showed that 33 of 36 staff surveyed felt well supported by the iMobile team when they had a deteriorating patient.

Data from the trust showed that the mean time (minutes) to review following referral to the iMobile team was 26 minutes in June 2017 and 13 minutes in July 2017.

Each bed area within the critical care unit had a patient board with clear information about the staff looking after each patient, expected date of discharge and patient safety alerts such as their allergies.

**Nursing staffing**

A matron led each designated critical care unit. The matrons reported to the clinical lead nurse for critical care and the head of nursing for critical care. We observed the nurses in charge of each CCU were supernumerary in line with the Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) standards.

Details of the actual number of nursing staff are provided below:

**DR56 - Actual vs establishment for nursing staff**

<table>
<thead>
<tr>
<th></th>
<th>Est</th>
<th>Actual</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christine Brown CCU</td>
<td>100.85</td>
<td>99.3</td>
<td>1.55</td>
</tr>
<tr>
<td>Frank Stansil CCU</td>
<td>79.55</td>
<td>85.76</td>
<td>-6.21</td>
</tr>
<tr>
<td>Jack Steinberg CCU</td>
<td>94.98</td>
<td>96.92</td>
<td>-1.94</td>
</tr>
<tr>
<td>LITU</td>
<td>105.42</td>
<td>102.02</td>
<td>3.4</td>
</tr>
<tr>
<td>iMobile</td>
<td>13</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>393.8</strong></td>
<td><strong>397</strong></td>
<td><strong>-3.2</strong></td>
</tr>
</tbody>
</table>

Most critical care units had established numbers of nursing staff. Senior staff informed us there was an ongoing recruitment drive in anticipation of the new critical care unit, which was expected to open in March 2018.

Nurse staff levels across the CCU and all HDUs were within national guidance. All the CCUs had 1:1 nursing care for level three patients and at least 1:2 nursing care for level two patients. The HDUs also had 1:2 nursing care for level two patients.

We found nurses stationed at patient’s bedsides most of the time. However, we observed instances on Jack Steinberg and Frank Stansil CCU where some patients requiring one to one nursing were left unobserved for some time. For example, we observed there were four nurses to eight patients on Frank Stansil CCU around lunchtime on the second day of our inspection. These included six level three patients and two level two patients.

Senior staff informed us they very rarely used agency staff on the CCUs, as they preferred to
recruit bank staff within their own team. Senior staff on Kinnier Wilson HDU informed us they used the trust bank staff as well as agency staff. They offered the same lines of work to agency staff to ensure they were familiar with the unit. In addition, agency staff were inducted to the unit and received similar training with permanent staff.

Nursing staff conducted handovers twice daily with the whole team in the morning and in the evening. We observed morning handovers on Jack Steinberg Ward and LITU and found them to be structured, detailed and with a focus on personalised care. Nursing staff received an overview of all critical care patients at the start of their shifts and then a thorough bedside handover once they were allocated a patient. Handover sheets were comprehensive and there were discussions about patient's social and medical history, their treatment plan and details regarding current observations.

The unit held a critical care safety briefing every morning were staff discussed patient risk assessments, admissions and discharges, ward rounds and other concerns.

**Medical staffing**

A clinical director led the critical care supported by a clinical lead for each unit. Medical staffing consisted of 34 consultants, 16 senior clinical fellows and 27 clinical fellows. In addition, there were 40 junior doctors of various grades. During the period of our inspection, there were three consultant vacancies, three vacancies for senior clinical fellows and two vacancies for clinical fellows.

Senior medical staff confirmed they used locums who had previously worked at the trust. They confirmed if sourced through agencies, they ensured that such locums were inducted into the unit.

The Guidelines for the Provision of Intensive Care Services (GPICS) recommends the consultant/patient ratio must not exceed a range between 1:8 and 1:15 and the CCU resident/patient ratio should not exceed 1:8.

The consultant/patient ratio was higher than the recommended national guideline with one consultant rostered to cover each critical care unit. This meant patient to consultant ratios on all but one critical care unit (Frank Stansil CCU) had a ratio of one consultant to 18/19 patients. Senior staff informed us there were plans to address this when the new critical care unit opened next year.

During night shifts, there was one junior doctor rostered to cover each critical care unit. There were two airway-trained staff rostered to provide cover at night and staff informed us consultants often stayed late to cover shifts. The two airway trained staff were also responsible for outreach patients. During the day, junior doctors were rostered to cover a number of short and long shifts with an average of four doctors per unit.

A HDU lead consultant led Kinnier Wilson HDU. There was a dedicated trainee on the ward 24 hours a day, seven days a week. Neuro surgeons reviewed patients on daily basis and on call cover was provided by the neuro surgery ward.

We observed a medical handover on the LITU. Consultant led medical rounds were appropriate, with a full review of each patient’s history, medicines and treatment.

**Major incident awareness and training**

The trust was one of the major trauma centres in South London.

The major incident policy was up to date and had appropriate action cards for critical care staff on how to act in the event of an emergency. These included options for increasing level three bed capacity as well as options for creating level two capacity.
The major incident plan was actioned in at least three significant incidents in the last six months prior to our inspection. Staff confirmed they were able to create level three CCU beds without moving patients out of the unit. They did this by reviewing patients who were ready for discharge and patients who they could step down to other units. The CCU received many letters of support from members of the public and governmental bodies thanking staff for the care provided to patients during these incidents.

Is the service effective?

Evidence-based care and treatment

There were clear policies and procedures in line with best practice guidelines. This included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society (ICS) recommendations. Staff had access to guidelines on the trust's intranet system. In addition, there were guidelines for day-to-day bedside activities attached to each patient's trolley. These included guidelines regarding ‘Waterlow’ score assessments; Glasgow Coma Scale, care of liver patients, Richmond Agitation and Sedation Scale (RASS), Confusion Assessment Method (CAM), Critical-Care Pain Observation Tool (CPOT). There was a quick reference telephone list amongst others. We observed the guidelines were in date and had been updated two months prior to our inspection.

The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCN). The network’s peer review report dated June 2017 highlighted the CCU’s performance against Critical Care Service Specific Standards (D16) 2015. It showed that whilst the service fully or partially met most of the standards, there were several areas of concern. The CCU did not meet standards regarding facilities in critical care areas, daily input from multidisciplinary staff during ward rounds, timely transfer of patients to a trust closer to their home following specialist critical care, assessment of rehabilitation needs within 24 hours of admission and rehabilitation prescription on discharge.

The trust informed us they were putting an action plan in place to address areas of concern highlighted in the recent SLACCN peer review report. They had submitted a business case for additional funding to support allied health services. In addition, there were increasing CCU capacity by 16% with the opening of the first phase of the new CCU building in spring 2018.

The Critical Care Unit (CCU) contributed 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 across the UK.

There was a local audit programme in place to ensure certain audits were completed monthly such as catheter audits and venous thromboembolism (VTE) assessment audits. The CCU also completed quarterly reports in relation to the ventilator-associated pneumonia (VAP) prevention bundle compliance audit.

The 2016/17 VAP incident and prevention report analysed VAP prevention bundle audits and the effect of implementing recommendations from previous audits. The results of the audit showed VAP rates had improved following the implementation of a standardised VAP prevention bundle. It also showed Christine Brown CCU, which had the lowest compliance rate (74%), also had the highest rate of VAP (45/1000). The Liver Intensive Therapy Unit (LITU) had the highest compliance rate of 91%; it also had the lowest rate of VAP (15/1000). Following the introduction of subglottic suctioning endotracheal tube (ETT), CCU VAP rates reduced from 28/1000 to 15/1000. Recommendations were made to improve VAP audit compliance to 95%, educate staff and adopt subglottic suction ETT as routine on the CCU.
We observed appropriate sepsis management from reviewing patient notes and staff administered antibiotics in line with guidelines. The iMobile team had initiated a trial of “septic screen boxes” on four medical wards. The box contained key items to help staff easily recognise the signs of sepsis and enable them to treat patients swiftly. This meant staff on the ward could start using the septic screen pack before iMobile staff arrived to speed up treatment times and help ensure the best outcome for patients.

**Pain relief**

Our review of patient records showed that staff used a standardised scoring tool to assess patients’ pain and recorded pain assessments in patients’ notes. The Critical-Care Pain Observation Tool (CPOT) for non-communicating patients rates critically ill patients’ pain based on clinical observation. We observed the CPOT tool was in use on all units visited. Pain assessments were completed and pain scores recorded.

Patients also told us they received pain relief when they required it and that it was reviewed regularly.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool ‘MUST’ is a validated nutritional screening tool and is the most commonly used tool throughout the UK. It is a simple five-step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. Our review of 16 patient records showed that staff completed nutrition and hydration assessments for each patient. Supportive nutrition plans and food charts were in use and these had been completed.

We observed fluid monitoring in place for patients, which demonstrated hourly and daily fluid input and output totals.

Staff confirmed they had access to dietitians and could refer patients to them were necessary.

**Patient outcomes**

The trust had two units, which contributed data to Intensive Care National Audit and Research Centre (ICNARC). This included the medical and surgical critical care unit (Christine Brown CCU, Jack Steinberg CCU and Frank Stansil CCU), and the Liver Intensive Therapy Unit (LITU). These meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the most recent report dated 20 July 2017 (1 April 2016 to 31 March 2017).

For the medical and surgical critical care unit, the risk adjusted hospital mortality ratio was 0.98 in 2016/17. This was slightly better than similar units. The figure in the 2015/16 annual report was 0.94. For the LITU, the risk adjusted hospital mortality ratio was 0.91 in 2016/17. This was better than the national average. The figure in the 2015/16 annual report was 0.78.

For the medical and surgical critical care unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.93 in 2016/17. This was the same as the England average. The figure in the 2015/16 annual report was 1. For the LITU, the risk adjusted hospital mortality ratio was 0.95 in 2016/17. This was within expected limits. The figure in the 2015/16 annual report was 0.79.

Unplanned readmissions to the medical and surgical critical care units within 48 hours of discharge was 0.9% in 2016/17. This was better than the national average. Unplanned readmissions to the LITU within 48 hours (1.3%) were within expected limits for the unit.
ICNARC data from April 2016 to March 2017 showed there were 38 deaths on the LITU. This represented a mortality rate of 4.4%, which was better than the expected mortality rate. During the same period, there were 113 deaths on the medical and surgical critical care unit. This represented a mortality rate of 6.5%, which was in line with the expected range for the unit.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

The critical care unit had a dedicated practice development team. A band 8a senior education development nurse led the team. Seven Band 7 practice development nurses (PDNs) assisted the lead. Senior staff informed us there was one PDN to 75 nurses in line with the Faculty of Intensive Care Medicine (FICM) standards. Each critical care unit had a PDN allocated to them. The practice development team monitored nurse competencies to make sure they were up to date with current practice based on national benchmark standards. Staff confirmed they received reminders to update their training.

The FCIM standards for Intensive Care Units recommend 50% of critical care nurses should be in possession of a post registration award in critical care nursing. At the time of our inspection, about 39% of nurses across the four units had post registration qualifications in critical care. An average of 43% of nurses across the four units had completed a mentorship course, which enabled them to mentor other staff. A breakdown of the figures across the CCU is provided below:

<table>
<thead>
<tr>
<th>Mentorship Course</th>
<th>ITU Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christine Brown CCU</td>
<td>45%</td>
</tr>
<tr>
<td>Frank Stansil CCU</td>
<td>48%</td>
</tr>
<tr>
<td>Jack Steinberg CCU</td>
<td>41%</td>
</tr>
<tr>
<td>Liver</td>
<td>37%</td>
</tr>
</tbody>
</table>

The percentage of nurses with post registration qualifications was lower than the percentage (50% - 70% across the four CCUs) during our inspection in 2015.

Senior staff explained they had recently recruited a significant number of new staff. The CCU had experienced a recruitment drive in preparation for a new 60 bedded critical care unit, which opens in spring 2018. In addition, a number of senior staff members had progressed to senior positions within the trust thereby having an impact on the number of staff who had post registration qualifications. Senior staff informed us they aimed to achieve the recommended rate of 50% by December 2017.

There were systems to ensure staff were competent to carry out their role. New nurses went through a three-week supernumerary induction period to ensure they were familiar with local policies and procedures. They were allocated a mentor and were required to complete competency-based assessments before they were allowed to work without supervision. New nurses were able to undertake the post registration qualification in critical care following 12 months critical care experience. The post registration programme was undertaken in house and accredited by the ICS.

Staff confirmed they received adequate training to carry out their role including training in the use of equipment.
iMobile staff met the operational standards and competencies for critical care outreach services. The iMobile (CCU outreach) team consisted of 12 nurses including a lead nurse and band 7 and band 6 nurses. A consultant intensivists and registrars supported them. All nurses within the iMobile team had post registration qualifications in critical care and more than 3 years of CCU experience and mentorship.

Staff working within the HDUs had also gone through an induction period and completed competency assessments before they were allowed to work without supervision. They also received training tailored to the unit they worked on.

Senior staff informed us between 70% and 99% of staff have had an appraisal in the last year across the four critical care units.

Junior doctors received an orientation and induction programme following their employment. Each junior doctor was allocated a clinical supervisor and completed a clinical competency checklist. There were 34 consultants on the unit. The CCU had a medical lead and each ward a lead consultant. Most of the consultants led in various areas. There was a lead for the new build, research lead, neuro and trauma lead, iMobile lead, cardiac lead, audit lead, infection prevention and control lead, induction and teaching lead and faculty tutor amongst others.

The lead consultant monitored the training and audit programmes of doctors to ensure they implemented learning to improve practice. Medical staff used regular meetings, such as mortality and morbidity and governance meetings with the critical care delivery group to review practice guidelines and identify areas of good practice or areas of improvement. Junior doctors we spoke with were happy with the training and teaching they received in critical care.

**Multidisciplinary working**

Staff reported good working relationships with other teams. Our review of 16 patient records showed there was input from physiotherapists, pharmacists, dietitians and speech and language therapists (SaLT). We observed a medical handover on the LITU; the lead consultant for the unit led this. Nursing staff and a physiotherapist attended.

Senior staff on Kinnier Wilson HDU reported good working relationships with the CCU. This included an exchange programme between the CCU and Kinnier Wilson HDU so that they could work with CCU nurses and improve communication between the two units.

Staff on Kinnier Wilson HDU held multidisciplinary team meetings involving clinical nurse specialists (CNS), neurology rehabilitation consultants, neuro surgeons, trauma team and in patient psychiatry team. Best interest meetings were held for relevant patients and the team planned their healthcare.

Senior staff reported they had good working relationships with other local trusts and often sent some of their Band 6 staff to support other trusts. In addition, the critical care post registration course was delivered in partnership with a local trust.

The CCU was part of the South London Adult Critical Care Operational Delivery Network and staff from the CCU attended network meeting to share practice and learning.

Multidisciplinary team meetings took place weekly to review all long stay patients, those requiring rehabilitation and patients with complex needs.

Staff reported good working relationships with allied health professionals (AHPs) including pharmacists, physiotherapists, occupational therapists, speech and language therapist (SaLT) and dietitians. Staff said they could access AHPs easily and that they were supportive.
However, we found that pharmacy and therapy provision on the CCU was not compliant with Guidelines for the Provision of Intensive Care Services (GPIS).

The CCU had a dedicated pharmacy team consisting of 5.05 Whole Time Equivalent (WTE) pharmacists, 1 WTE pharmacy technician and 1 pharmacy assistant. There was a pharmacist attached to each critical care ward. Pharmacist conducted a ward round from Monday to Saturday. There was no pharmacy presence on the wards on Sundays and orders had to be taken to the pharmacy. The CCU was not compliant with the Guidelines for the Provision of Intensive Care Services (GPIS) standard requiring minimum 0.1 WTE pharmacist per bed.

Provision of therapy services did not comply with GPIS standard. A team of 3.5 WTE occupational therapist provided cover to the CCU. This meant there was a ratio of 0.04 therapists per bed against the required standard of 0.22 per bed.

A team of 7.5 WTE physiotherapist provided cover to the CCU. This meant there was a ratio of 0.11 therapists per bed against the required standard of 0.25 per bed.

A team of 2.89 WTE SaLT staff provided cover to the CCU. This was at a ratio of 0.04 staff per bed instead of 0.15.

Dietetic provision on the unit was by a team of 1.49 WTE staff. This was a ratio of 0.02 staff per bed instead of 0.1.

Seven-day services

Medical and nursing staff provided cover on the CCU for 24 hours a day, seven days a week. Consultants were present on the CCU for 12 hours a day and on call overnight within 30 minutes of the hospital reach.

Therapist provided mainly weekday services with a physical therapy service at weekends and on call.

There was a pharmacist attached to each critical care ward. Pharmacist conducted a ward round from Monday to Saturday and staff had access to the pharmacy on Sunday.

Staff reported good access to imaging services out of hours or at weekends.

Access to information

Staff received a verbal and written hand over when patients were admitted to the ward. Formal handover documentation was in place for patients being stepped down or discharged from the unit.

Staff had access to patients’ records on the electronic system. They also had access to patients’ paper records. Our review of patient notes showed they were comprehensive and included details of each patient’s medical history, GP and personal information details, assessments and test results.

Staff on Kinnier Wilson Ward used the HDU communication proforma for handover.

There was access to professional guidance, policies and procedures on the electronic system. Staff also received information with regard to learning from adverse events and changes in professional practice via email and on notice boards.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet. Staff were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff were aware of their responsibilities under the mental capacity act.

Our review of patient notes showed that staff completed neurological assessments with prompts to identify issues that may affect mental capacity. Consent forms were completed in line with established guidelines. Where a patient was unable to consent, relatives were duly consulted and best interest forms were signed.

Staff were required to complete restraint forms anytime mittens were used to prevent patients from accidentally removing intravenous lines and ventilator tubes. Restraint forms were required to be signed off by a consultant and we saw restraint forms were included in patient’s records. Our review of patient notes showed that restraint forms were duly completed and signed off by a consultant were required. In addition, staff reviewed the use of restraints twice daily to determine if a patient should be taken off restraint.

CCU training records show that 92% of nursing staff across the CCU and 84% of medical staff had completed the Mental Capacity act training.

The trust had achieved Accreditation for Inpatient Mental Health Services (AIMS) including Psychiatric Intensive Care Units (PICU).

Is the service caring?

Compassionate care

Patient, family and friends feedback on all the wards were mostly positive. Patients and their relatives said they had received “fantastic care, I can’t fault it at all” “wonderful care” and described staff as “brilliant” and “lovely”. One family said their relative received prompt attention including prompt investigations following their transfer from another hospital.

The CCU had received many letters of support from members of the public and governmental bodies thanking staff for the care provided to patients following recent major incidents in London. A correspondence from the trust’s chief nurse was on the notice board within the critical care units, highlighting details of the letters received.

All observations of care we made were positive, with staff showing kind and compassionate care. We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing the curtains around patient areas before completing care tasks. Patients on the Liver Intensive Therapy Unit were cared for in individual cubicles with slide doors, which guaranteed their privacy during assessments. Both patients and relatives said staff were visible and caring.

The 2017 patient and relatives iMobile survey results showed that 100% of 20 patients/relatives surveyed felt they were treated with respect and dignity. Some of the comments left in relation to dignity and privacy included “Magical, made me feel so at ease”, “staff were courteous and caring” and “absolutely with dignity and respect”.

All the respondents felt the iMobile staff’s rate of courtesy was excellent. Some of the comments left included “Excellent is an underrated evaluation”; “Doing a wonderful job. Seemed very dedicated to their chosen profession”; and “iMobile nurse always smiles and is friendly”.

Between July 2016 and June 2017, the results of the NHS friends and family test showed 99% of patients would recommend the CCU.

*(Sources: DR146, DR296)*

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

Most of the patients we spoke with confirmed staff introduced themselves, explained procedures and obtained their consent before conducting them. Most relatives also confirmed they were informed about patient care. One family said they had a “very sensitive and private discussions with the patient’s doctor”. However, one family felt they had not received regular updates about patient care. They felt they always had to ask for information before they received an update. One relative felt unhappy about the time restriction to see a patient on the unit. However, they confirmed the matron was very understanding and allowed them to see the patient in exceptional circumstances.

Specialist nurses for organ donation worked closely with the chaplaincy team to support families when their relative had been identified as dying and suitable for organ donation.

The 2017 patient and relatives iMobile survey results showed that 100% of 20 patients/relatives surveyed felt their questions were answered in a way they understood. All respondents felt involved in the decision making about their care. To the questions “did you feel adequately informed and prepared for you or your relatives discharge from the service”, 65% (13) indicated “yes”, 15% (3) had no reply, 15% (3) indicated “not applicable” and 5% (1) indicated “no”.

**Emotional support**

A multidisciplinary team including doctors, nurses, physiotherapists, pharmacists and a dietitian supported patients on the unit. Our review of patient notes showed that staff completed psychological assessments as well as psycho-social assessments to determine the needs of each patient. We observed there were prompts within psycho-social assessments to provide families with leaflets and relevant information following bereavements. Patients were referred to appropriate professionals were necessary. The units had a follow up clinic to support patients recovering from illness.

The CCU had a dedicated team providing specialist end of life care. The team provided staff support and bereavement support.

Emotional support was also provided by the multi-faith chaplain service within the hospital and representatives from various faith groups could be accessed.

**Is the service responsive?**

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

Over 3000 patients were admitted to the critical care units (CCU) in the last year. The CCU had clear admission guidelines and the guidelines were in date. The consultant on shift usually agreed admission to critical care. For emergency admissions, a referral to critical care was made through the iMobile team. The consultant or CCU registrar would make the decision to admit to critical care. Patients undergoing high-risk major surgery were booked into the CCU prior to the day of the planned procedure. The CCU consultant made the decision to proceed with elective admission considering the bed capacity, discharges and emergency admissions.
The Intensive Care National Audit and Research Centre (ICNARC) data from April 2016 to March 2017 showed the LITU’s main sources of admission were from the theatre (62%), other CCUs (15%), ward or intermediate area (14%) and emergency department (7%).

For the medical and surgical critical care unit (Jack Steinberg CCU, Christine Brown CCU and Frank Stansil CCU), the main sources of admission were from the emergency department (40%), theatres (29%), ward or intermediate areas (24%) and other critical care units (9%).

The trust’s critical care activity data showed that over 62% of patients admitted to the LITU between February 2017 and July 2017 required level three support, 34% required level two support while 4% required level one support. During the same period, over 69% of patients admitted to the medical and surgical critical care unit required level three support, 27% required level two support and 4% required level one support.

The critical care unit had been at over 100% bed occupancy in the last 12 months. There was limited storage space on the critical care units (CCU) and we found equipment kept on corridors on the units. Senior staff recognised capacity as the main risk on the unit and existing facilities were insufficient to meet the demands for the unit. Bed spaces on some of the wards visited, in particular Jack Steinberg ward were cramped and did not meet the specifications of Department of Health’s Health Building note.

To this end, the trust had implemented plans to open a new 60-bedded critical care unit making it one of the largest critical care units in the country. The use of Jack Steinberg ward as a CCU would cease with the opening of the first phase of the new CCU in June 2018.

Patients had access to a follow up clinic after they were discharged from the units. Discharge summaries from the CCU were sent to family doctors (GPs). The follow up team liaised with GPs to arrange counselling, psychiatric support, rehabilitation services and other clinical services.

Relatives had access to a visitor’s room on each critical care unit and on the HDUs. With the exception of the visitor's room next to Jack Steinberg ward, most visitors’ rooms were very small.

(Sources: ICNARC – 6 June 2017)

**Meeting people’s individual needs**

Staff confirmed that they could access interpreting service for patients through a help line. They could also request for face-to-face interpreting services when required.

Patients were provided with a menu with a variety of meals to choose from. Food menus offered a range of options including softer choices, vegetarian, kosher amongst others. If a patient had any specialist dietary requirements staff would record this. Patients were enabled to eat independently and drinks were placed within their reach. We observed nurses assisting patients when required. Patients who were able to eat told us they were happy with the food choices available on the unit.

Some of the relatives we spoke with confirmed they were able to call the ward and have their messages relayed to their family member on the ward.

We observed a bed area on the LITU was decorated with family pictures of the patient thereby personalising the cubicle for the patient.

We observed that a patient who was admitted to the CCU following delivery of a baby was placed in one of the side rooms on Frank Stansil CCU. This provided the patient with privacy especially when expressing milk for the baby.
Visiting times were flexible outside of the advertised hours, so friends and family could visit when it was convenient for them.

A trust wide specialist team of nurses in delirium was in place and staff carried out screening for delirium.

Patient’s mental health status was recorded and staff could make referrals to a psychiatric team if necessary. Staff on Kinnier Wilson HDU completed a violence and aggression risk assessment for patients. Staff referred families to a brain injury charity, which provide great support for families of neurology patients.

Staff completed psychosocial assessments, which included prompts to identify any safeguarding concerns. Staff reported safeguarding concerns to the safeguarding team and there were social workers attached to the CCU.

The learning disability team were referred to if a patient was identified as requiring additional support for their needs.

Relatives had access to drinking water and beverage facilities on most of the units visited. In addition, there were several cafes within the trust's premises accessible to all visitors. There were leaflets on a variety of topics including chaplaincy visits, the complaints procedure, NHS organ donation, Priest and chaplaincy visits, and police liaison officer.

There was a quiet room available for relatives on LITU and doctors could discuss confidential information with relatives.

One relative complained about the lack of toilet facilities for visitors on LITU and said they had to walk down to the main entrance of the hospital to go to the toilet.

Staff assessed family needs from admission documents and proactively arranged support for families. For example, long-term arrangements were often made to cover car parking costs. They also link families with charities to help with general cost and accommodation close to the trust. One of the relatives we spoke with confirmed they were provided with accommodation near the trust in the first week of their relative’s admission. They were then linked with a charity, which provided them with further accommodation near the trust for the rest of their stay.

Staff provided examples of how they supported families following major incidents in London. This included liaising with social workers to provide accommodation for families who had lost everything in a fire.

It was not clear how patients living with dementia were identified and we did not see evidence of any relevant documentation in the patient notes.

Information received from the trust indicates there were no mixed sex breaches on the CCU. A mixed sex breach occurs when level one or zero patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. The trust indicates only 4.8% bed days were occupied by level one patients in the last six months. Senior staff informed us that on the rare occasions when level one patients were in the CCU, they were separated in individual cubicles.

Access and flow

Following on from our last inspection in 2015, the average bed occupancy on the CCU was still very high. However, the unit performed better than the national average on a number of areas.
Between February 2017 and July 2017, the average bed occupancy on the LITU was 107%. During the same period, the average bed occupancy on the medical and surgical critical care unit was 104%. These occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency.

Senior staff said they had good working relationship with the site management team to manage patient flow. In addition, the iMobile team worked with nurses on the ward to proactively manage early signs of deterioration in patients in order to avoid admissions to the critical care units.

The CCU had a team of two Band 7 bed managers with the aim of maintaining patient follow and promoting safe and timely admissions and discharges. The role involved constant review of hospital wide bed availability. We attended one of the CCU bed meetings which was led by a bed manager. The meeting was attended by senior nurses and consultants. Staff discussed the number of possible discharges and admissions for the day.

Data from the trust showed there were 777 (87%) delayed discharges (greater than four hours) from the medical and surgical critical care units between February 2017 and July 2017 out of 892 discharges. During the same period, there were 408 (72%) delayed discharges from the LITU out of 582 discharges. Staff told us delayed discharges occurred due to lack of suitable beds on the wards.

ICNARC data for the medical and surgical critical care unit showed there were 10010 available bed days. The percentage of bed days occupied by patients with discharge delayed by more than 8 hours was 5.8%. This compared to the national aggregate of 5.1%. This meant the unit was not in the worst 5% of units nationally. The percentage of bed days occupied by patients with discharge delayed by more than 24 hours was 3.9%. This compared to the national aggregate of 3.1%.

ICNARC data for the LITU showed there were 6571 available bed days. The percentage of bed days occupied by patients with discharge delayed by more than 8 hours was 2.3%. This compared to similar units (4.6%) and national aggregate of 5.1%. The percentage of bed days occupied by patients with discharge delayed by more than 24 hours was 1%. This was better than similar units (2.7%) and the national aggregate of 3.1%.

Patients discharged from critical care ‘out of hours’ between 10pm and 7am are nationally associated with worse outcomes. ICNARC data from April 2018 to 31 March 2017 showed that 23 (2.7%) patients on the LITU were discharged ‘out of hours’. This was in line with expected limits for the unit. During the same period, 17 (1.3%) patients were discharged from the medical and surgical critical care unit. This was better than the England average.

ICNARC data showed non-clinical transfers out of the LITU was 0.2%. This compared to the national average of 0.4%. Non-clinical transfers out of the medical and surgical critical care unit was 0.3% compared to the national average of 0.4%.

The length of stay on the CCU had improved since our last inspection in 2015. Between February 2017 and July 2017, the average median length of stay on the LITU was three days. During the same period, the average median length of stay on the medical and surgical critical care units was four days.

Thirteen elective surgeries were cancelled in the last 12 months due to lack of critical care bed on the medical and surgical critical care units. One elective surgery was cancelled due to lack of critical care bed on LITU.
Our review of patient records showed that most patients were admitted within four hours of the decision to admit being made. Data from the trust showed there were only nine delayed admissions out of 181 unplanned admissions to the CCU between May 2017 and July 2017.

(Sources: ICNARC – 3 July 2017)

Learning from complaints and concerns
Staff informed us that they escalated complaints to their managers and also directed patients and relatives on how to make complaints and referred them to the Patient Advice Liaison Service (PALS) were necessary. We found leaflets on all wards visited informing people about how to make a complaint.

Between June 2016 and June 2017, there were 11 complaints about services at the CCU. These included one at Christine Brown CCU, two at Frank Stansil CCU, two at the LITU and six at Jack Steinberg CCU. In addition, there were seven complaints about services at the HDUs. These included two at Kinnier Wilson HDU and five at Victoria Albert HDU.

Information provided by the trust indicates complaints were reviewed and signed off either by the Executive Medical Director or Chief Nurse with a covering letter from the Chief Executive. Complaints were linked to the Adverse Incident process as appropriate. We noted that all complaints we reviewed in the CCU had an outcome and a resolution date.

(Source: Trust Provider Information Request )

Is the service well-led?

Leadership
A clinical director and a head of nursing led the critical care service. A clinical lead nurse supported the head of nursing. A clinical lead and a matron led each critical care unit.

Staff told us they were supported by senior management in critical care including the clinical director, head of nursing, consultants and matrons. Staff said the managers were visible and approachable.

The high dependency units (HDUs) including Kinnier Wilson HDU (Neuro HDU) and Victoria and Albert HDU (cardiac HDU) were managed under a separate division of the neuro science and cardiac wards. Each of the HDUs had a clinical lead as well as a matron. Staff on the HDUs also felt supported by senior management and felt managers were visible and approachable.

During our inspection, we found that senior staff were visible on the wards and knew staff across the service.

Lines of accountability and responsibility on the units were clear and staff understood their roles and how to escalate problems. A band 7 nurse led each critical care team.

Junior doctors told us they felt supported by their consultants. They told us consultants often stayed beyond their shifts to support the team.

Vision and Strategy
In April 2016, King’s College Hospital NHS Foundation Trust developed its “BEST” strategy (Best quality care; Excellent teaching and research; Skilled “can do” teams and Top productivity) where
patients come first and receive the best care and services. The trust aimed to be an outstanding local hospital at the heart of the communities it served and a world-class centre for specialist clinical, teaching and research excellence. Staff were aware of the vision to provide the best care for patients.

Within the local critical care unit, staff were aware of the department’s plans for a new critical care unit and could verbalise the plans. Staff were positive about developmental plans for the new unit and felt that it would allow more facilities for families. In addition, there was optimism that the new unit would alleviate the capacity issues in critical care.

**Culture**

All the staff we spoke with reported there was a positive culture within the units. They said they were happy to come to work and several staff had worked with the trust for a number of years. Staff felt they had opportunities to develop in their role and felt they worked within a very good team. We found a number of nurses had started as a band 5 staff nurse and had risen through the ranks. Staff felt they could report concerns. For example, one staff said she had reported concerns about staffing and had their concerns addressed.

Staff said they had good working relationships with other team members within the unit. They said the unit was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and followed the correct process.

As at June 2016 to May 2017, the CCU reported a turnover rate of 16.8% for qualified nursing and midwifery staff. This was lower than the trust’s target turnover rate of 20%. The CCU reported a sickness rate of 3% for qualified nursing and midwifery staff. This was the same as the trust’s target sickness rate of 3%

During the same period, the CCU reported an average turnover rate of 3.5% for medical staff. This was notably lower than the trust’s target turnover rate of 20%. Of note was a spike in the monthly turnover rate in August 2016, when it was recorded as 14%. The CCU reported an average sickness rate of 2.6% for medical staff. This was below the trust’s target sickness rate of 3%.

**Governance, Risk Management and Quality Improvement**

Senior staff held monthly risk and governance meetings to address several issues including red and amber serious incidents (SIs). We reviewed the minutes of the last two meetings and these showed that the meetings were well attended by senior staff including medical leads, the head of nursing, clinical nurse lead, matrons from each critical care unit and the patient safety manager.

Senior staff discussed the incidents on the unit and disseminated information to staff on the ward. Senior staff also discussed issues on the risk register, patient safety audits and compliance, infection control amongst others. We saw details of top risks and SIs highlighted in information provided on the notice board within the units. Staff also confirmed these incidents were discussed during staff meetings and they received emails regarding these.

Senior nurses held a meeting every four to six weeks attended by matrons, band 7 nurses, the deputy head of nursing and head of nursing.

Risk management had improved since our last inspection in 2015. The CCU maintained a risk register including concerns and assessments of potential risks on the unit. Mitigating plans were
put in place to address those risks and senior staff routinely discussed risks at clinical governance meetings. The risk register showed the date each risk was added, and staff recorded the dates they were reviewed. The risk register also captured relevant risks found during our inspection. There were 14 risks on the risk register in relation to critical care services at Denmark Hill. Three of the risks were in relation to Christine Brown CCU, two in relation to Frank Stansil CCU, five in relation to Jack Steinberg CCU, and four were in relation to the LITU.

Senior staff on the critical care unit identified their main challenges as capacity, delayed discharges, and medical staffing. These risks featured prominently on the risk register and there were mitigating plans in place to address them. A team of advanced critical care practitioners (ACCPs) had been recruited to support medical staff on the unit. The ACCPs will undertake two years university training, which starts in October 2017. In addition, the CCU was actively recruiting for additional registrars and the CCU had put in a business case to recruit additional consultants.

Senior staff on Kinnier Wilson HDU identified their main challenges as staffing and the environment. Senior staff explained there was a national shortage of nursing staff. In order to attract the best team, they had improved what they offered staff to include better training for staff and accommodation for the first two months of their employment. In addition, they had a practice development nurse on every ward to mentor and support new recruits. In order to alleviate the risks in relation to the environment on Kinnier Wilson HDU, staff reduced bed capacity from 12 beds to 11.

Public and Staff Engagement

There were a number of public engagement initiatives to promote feedback. Patients, friends and family had been involved in a pathfinder group to plan the new critical care unit. The trust had considered the effect of serious injury on patients and the need for a calm and quite environment for patients to recover. Information from the trust indicated the new critical care unit would offer natural light, uplifting artwork and home comforts to create a more healing experience.

Relatives’ questionnaires were being completed and boxes for these were in waiting rooms. Follow-up clinics were held with patients and their family and friends, which included a feedback element.

There were regular staff meetings and senior staff fed back relevant information to staff.

Notice boards within the units and staff rooms had current information about serious incidents, audits, research and mandatory training reminders. Staff had access to a coffee room/kitchenette on all units visited. These had facilities for making beverages, fridges and storage.

Learning, continuous improvement and innovation

The use of Jack Steinberg CCU as a Critical Care Unit would cease with the opening of the first phase of the new Critical Care Unit in June 2018. The new CCU would provide a 60-bed facility including a six-bedded roof garden. The first phase of the new CCU was expected to open with 29 beds and the second phase of the unit was due to open with 31 beds in October 2019.

Practice development nurses (PDNs) within the CCU work with another London trust to deliver studies to CCU nurses. One of the PDNs was a nurse lead for the critical care network in South London.

Christine Brown CCU was awarded the ward of the month in April 2017.
Research projects on Kinnier Wilson HDU explored relationships within families following brain injury in order to explore how family therapy can intervene in long-term outcomes.

Electronic mobile units where in place on Frank Stansil CCU, Christine Brown CCU and Kinnier Wilson HDU. There were plans to roll out electronic systems on all critical care units so that patient notes would integrate with the current trust systems, national critical care systems and primary care.

iMobile were not just an outreach and rapid response team, but also followed up critical care discharges and delivered critical care in ward beds. It was made up of a multidisciplinary team and was proactive as well as reactive, monitoring early warning scores (via an automated electronic alert system) without requiring a referral. The iMobile team also delivered teachings and workshops to staff.

The iMobile team had initiated a trial of “septic screen boxes” on four medical wards. The box contained key items to help staff easily recognise the signs of sepsis and enable them to treat patients swiftly. This meant staff on the ward could start using the septic screen pack before iMobile staff arrived to speed up treatment times and help ensure the best outcome for patients.

Information from the trust indicated the Anaesthetic, Critical, Emergency Medicine and Trauma (ACET) research team was the largest research group of its kind in the UK. They had supported over 50 National Institute for Health Research (NIHR) portfolio studies: several Chief Investigators and five medical/nursing PhDs. This had occurred across basic science, translational and health services research, including immune therapies; extracorporeal support systems and transfer of care.

The trust was a major trauma centre, tertiary liver including liver transplantation centre as well as a tertiary cardiac including cardiac arrest centre. This meant the CCU often cared for very sick patients with poorer outcome expectations. Notwithstanding the acuity of patients cared for, the CCU had better than average patient outcomes when compared with similar units. The CCU had provided us with several success stories of treating patients with extra-corporeal membrane oxygenation (ECMO) despite the severity of their illness.

**Diagnostic Imaging**

The main radiology imaging service at King’s College Hospital served the local population. In 2016, 337,288 imaging tests were conducted across all imaging modalities. A further 44,481 imaging tests were conducted in the dedicated neuro-imaging department in 2016.

The service offers general x-ray, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound, interventional, breast imaging and nuclear medicine as well as a wide range of neuro-imaging modalities.

The main imaging department has seen growth of 38.3% across all types of activity over the past decade at King’s College Hospital (KCH).
We inspected the main radiology department during our visit. Over the inspection days we spoke with 12 patients across the services. We also spoke to a wide range of staff at all levels including nurses, managers, administrative staff, radiographers and radiologists.

Is the service safe?

Incidents

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between 1 July 2016 and 30 June 2017, the trust reported no incidents classified as never events for diagnostic imaging.

Breakdown of serious incidents reported to STEIS

The trust reported 245 adverse incidents (AIs) in diagnostic imaging which met the reporting criteria set by KCH incident reporting policy between 1 April 2016 and 30 Mar 2017. Of these incidents 143 were under local review and 13 required a full root cause analysis, (RCA). The remaining 89 incidents were being monitored for any ongoing trends. The staff member responsible for reviewing the RCAs was able to describe in detail the process followed.

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report on the electronic system. Staff consistently reported incidents and demonstrated knowledge of how to do this. The accident and emergency imaging staff had reported an incident involving a patient who had become aggressive in one of the general x-ray rooms. The incident was investigated and new measures were now in place to improve the safety and security of staff working in the area.

When things went wrong in the diagnostic imaging department, robust reviews and investigations were carried out and lessons were learned. We saw examples of newsletters sent to all staff outlining the recent incidents and lessons to be learnt. For example, following an incident of a wrong patient being x-rayed, a copy of the department identification policy and the Society of Radiographers ‘pause and check’ document was sent to all staff. Action was also taken as a result of investigations, for example, following several incidents involving injection of contrast media in
CT, a new system was set up to allow a pre injection of saline prior to the contrast medium being injected. This allowed for safe checking of the position of the patient’s cannula.

The diagnostic imaging service ensured that exposures that were ‘much greater than intended’ were notified to the Care Quality Commission under The Ionising Radiation (Medical Exposures) Regulations 2006 (IRMER) or to the Health and Safety Executive (HSE) under Ionising Radiation Regulations 1999 (IRR99). There were strong systems in place to minimise the potential risk of harm from radiation exposure. For example, a full set of trust procedures for medical exposures were up to date and located on the trusts’ shared document file.

Four incidents occurred across both diagnostic imaging sites at King’s College Hospital and were reported as required under the regulations. The cases were now closed with the recommendations from the investigations implemented and ongoing monitoring in place to minimise the risk of similar incidents occurring in the future.

A reporting tracker to ensure that all such incidents were thoroughly and timely reviewed in order to meet the requirement above was now reviewed at monthly clinical governance meetings.

The diagnostic imaging department were inspected by the CQC as regards their IRMER policies and procedures in October 2016. We looked at the report and noted the minor recommendations made by the inspection team had now been implemented.

Staff told us that the radiation protection service located within the trust was very responsive and supportive in all matters dealing with radiation safety. Each radiology area had a named radiation protection supervisor (RPS) who were accountable to the onsite Radiation Protection Advisor (RPA). We noted the local rules governing the use of radiation in each room had been updated to reflect the recent changes in RPS provision.

**Cleanliness, infection control and hygiene**

All the imaging rooms and waiting areas we visited were visibly clean. We observed hand sanitiser units throughout the department but did not observe any staff using these as they left and re-entered the x-ray rooms. All the staff we observed in the clinical areas were ‘bare below the elbow’ in accordance with the national institute for clinical excellence (NICE) guidance.

The cleanliness of the diagnostic imaging department was audited on a weekly basis. Hand hygiene audits were undertaken on a monthly basis. The results for the last three months demonstrate compliance of 97-98%. Staff explained how standards of cleanliness and hygiene were maintained. We saw evidence of completed cleaning schedules and we saw evidence that equipment was labelled as clean.

The nursing staff within diagnostic imaging were able to describe the procedure they would follow for treating patients with confirmed and suspected infectious diseases. The matron told us there was a detailed plan for the department which was later confirmed by the radiography staff we spoke with. The diagnostic imaging department employed two dedicated housekeepers who followed the guidelines for deep cleaning as required.

There were adequate supplies of personal protective equipment (PPE) including gloves and apron dispensers. Infection control policies were available on the intranet and staff were able to show them to us easily. We observed good waste streaming into the correctly labelled bins and containers.

The department reported 65% of medical staff and 81% of radiography staff had attended infection prevention and control training against a target of 90% in the year to date. 100% of staff were compliant with the Aseptic Non Touch technique training.
**Environment and equipment**

The imaging service ensured that ionising radiation areas had arrangements in place to control the area and restrict access. We noted the warning signs were working correctly at the time of the inspection.

We reviewed three resuscitation equipment trolleys across the diagnostic imaging areas. We found all equipment to be in date and stored correctly. However, the resuscitation unit in accident and emergency radiology was on the corporate risk register. We spoke with a member of staff about this and they told us the trolley covers a large and busy area and items are not always replaced after use. The staff member was not sure how this was to be addressed going forward.

Quality assurance checks for all the diagnostic imaging equipment was in place. These are mandatory checks based on the IRR99 and IRMER regulations to protect patients against unnecessary exposure to harmful radiation. There had been a new imaging room recently installed within the department. The RPA told us the room had been fully commissioned for use and an audit was in place to monitor radiation doses.

The age of the imaging equipment had been on the local and corporate risk registers for some time. Plans for replacement were being progressed with new x-ray rooms in the process of installation and a business plan being written to look towards a comprehensive managed service for existing and new equipment.

Risk assessments were in use. Staff were seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.

A full asset register was used to document the make, model, life expectancy and replacement plans for the diagnostic equipment.

Some of the patient waiting areas contained large glass storage cabinets for radiology equipment supplies. We noted boxes of contrast media stored on the floor in the CT area. Staff told us space was very difficult to find as the department had outgrown the area. The overall decoration was ‘tired’ with limited visual appeal. Some of the waiting areas had a children’s area with some toys but again this was very limited.

**Medicines**

The hospital had a policy for the safe management of medicines and staff had access to it on the hospital intranet.

There were reliable systems for storage of medicines in diagnostic imaging. Medicines were stored in locked cupboards and the nurse in charge of the relevant areas held the keys. The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation.

Radiographers could prescribe and administer contrast for CT procedures according to patient group directions (PGD). We saw the PGDs were in date and signed as required.

**Records**

The staff we spoke to in diagnostic imaging had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended.
The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient’s imaging history. There was a combination of paper requests (largely from GP’s) and internal electronic requesting. Paper requests were scanned onto the radiology information system. All requests were checked on receipt by either senior radiographers or consultant radiologist.

Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure.

Images were available to view via the Picture Archiving and Communications Systems (PACS) and could be shared across sites.

**Safeguarding**

The patient identification policy for diagnostic imaging was in place and had been reviewed in July 2017. It identified a three point check i.e. patient name, DOB and address. Four radiographers confirmed they checked patient name, DOB and address as part of the ID check.

The hospital had policies for safeguarding children and vulnerable adults.

The staff we spoke with were able to demonstrate they understood safeguarding processes and how to raise an alert. They told us there were good relationships with the trust safeguarding lead. All safeguarding training for radiographers was at 100% compliance.

**Mandatory training**

The trust set a target of 80% for completion of mandatory training. Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding. A new electronic system had recently been put in place across the hospital. Staff found the system easy to use and were able to track more easily their own mandatory training compliance. All staff we spoke to were up to date and evidence of this was seen on the day of inspection. However, the trust records showed a variance of compliance rates with manual handling at 73% for radiographers and information governance at 43% for medical staff. It should be noted there remained a number of months in the current year in which outstanding training could be completed.

The medical physics team provided radiation protection training for the Radiation Protection Supervisors (RPS) and all staff were currently up to date with this training.

**Assessing and responding to patient risk**

The hospital had a medical physics expert and a radiation protection advisor available and contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance.

The diagnostic imaging department had named Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. They were adequately trained and had all attended training. Quality assurance tests on the x-ray equipment were done daily prior to the service starting. Any trends or increases in exposure were reported to the RPS and investigated immediately.

Dose reference levels were displayed in all x-ray rooms. The Ionising Radiation Medical Exposure Regulations (IRMER) employer’s procedures were up to date and organised into a comprehensive document. We saw local rules were available for all staff to follow in the imaging areas we visited. These were not clearly visible on some of the mobile imaging equipment. However, staff were aware of the local rules and how to use them in their practice.
Radiation risk assessments were done when new equipment was installed. We saw the commissioning documents for the new digital x-ray rooms. Any issues identified had been addressed.

There was clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility they were pregnant. We saw examples of completed ‘last menstrual period’ forms scanned onto the radiology information system. The forms were signed by patient and radiographer.

We saw the World Health Organisation (WHO) surgical safety checklists being used in the department.

**Nursing/ radiography staffing**

There were dedicated nurses and radiography assistant staff across the department. There were fifteen interventional radiography nurses. Senior nursing staff told us the team was stable and all posts were recruited to.

On reviewing the vacancy data for radiographers from May 2017 -July 2017 there had been a decrease in the rate from 16.5% to 14.9%. This was higher than the target vacancy rate of 8%. However, senior staff told us the recent recruitment campaigns had been successful and with MRI radiographers at full establishment and newly qualified radiographers in the process of starting with the trust. Some agency staff were working on the day of the inspection. Staff told us they worked well within the team. There was a shortage of sonographers across the ultrasound service.

Diagnostic imaging services offered student radiographer placements. We spoke with two staff members who had previously been students at the hospital. They felt the department offered them good support and a varied career pathway.

There was a monthly sickness tracker in use, which showed sickness levels were below 3%. Monthly sickness case conferences for the department were held with the aim of adhering to the policy and offering additional support where required.

**Medical staffing**

Following some negative feedback from the 2016 General Medical Council trainee survey and further visits from Health Education England in early 2017, fourteen radiology registrars were removed from the service in April 2017. As an interim measure, five locum consultants were employed in May 2017 to cover the service gap. We saw the locums were given a comprehensive induction, a timetable of work and had their reports audited to ensure the service was safe. Replacement and additional permanent consultant posts were subsequently planned to meet the overall requirement for consultant-led service activities.

At the time of the inspection 15.3 whole time equivalent medical consultant posts were underway. Recruitment was positive with five radiologists fully recruited and a further six currently going through the recruitment process. The medical director was confident that all posts would be filled by the end of the year, although neuro imaging and the radiology sub speciality of ‘gastrointestinal (GI) was anticipated to be more challenging.

A further six trust-funded clinical fellows were also being recruited to increase radiology workforce. Two were in post in general radiography and one within the ultrasound service.

**Major incident awareness and training**

The trust had a major incident plan in place. This had been put into operation during recent terrorist attacks in London. There was a major incident folder in accident and emergency x-ray.
Staff had given feedback on how to improve their responsiveness as a department to major incidents. A disposable whiteboard was now in place to quickly outline staff roles and responsibilities. Also automated phone calls for the radiography leads were sent from switchboard. The first lead on site would take the position of bronze command for the major incident.

**Is the service effective?**

**Evidence-based care and treatment**

The hospital had a named radiation protection advisor (RPA) whose role was to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations. The RPA initiated and led testing of new digital equipment to enable the department to deliver best practice on dose and exposure management. Radiation dose levels were audited regularly and evidence seen on the day of the inspection. The RPA was aware of the new radiation safety legislation due to take effect in 2018 and the necessary steps to take for compliance.

Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines. Relevant clinical guidelines and standard operating procedures were available for all imaging tests and staff were able to show these to us during the inspection.

We looked at a comprehensive set of audits undertaken in the department. Radiographers told us they attended regular audit days where results of the audits were presented to them. For example an audit of compliance with skeletal surveys in non-accidental injury (NAI) was presented in November 2016. The results of the audit emphasised the need for education of all clinicians and healthcare professionals in the protocol and guidance on skeletal surveys in children under two years of age for suspected NAI. The staff we spoke with referred to new guidance in NAI and how they were more confident in the protocol. A current audit was ongoing to measure compliance with the hospital naso-gastric tube policy.

**Pain relief**

Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures. A pain score was completed in interventional radiology in order to monitor a patient’s requirements for pain relief. Interventional radiology is a medical sub-specialty of radiology using minimally-invasive image-guided procedures to diagnose and treat diseases.

**Patient outcomes**

The department participated in local audits, national audits, benchmarking and peer review. Discrepancy meetings were held on a regular basis reviewing imaging reports. These complied with the standards from the Royal College of Radiologists for Learning from Discrepancies meetings (LDM). We looked at the summary of the LDMs for 2016 and saw that patient outcomes were reviewed and learning was shared.

**Competent staff**

All staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R. Nursing staff were trained so they were competent in the field of interventional radiography and also to undertake nurse led pre-assessment clinics.
New staff were expected to go through the comprehensive induction programme. This ensured new staff gained competencies for their job role in diagnostic imaging. The new radiology locums were given a full induction to the department. Audits were done on the standard of their reporting skills and some locums were replaced where the standard fell below expectations.

Continual professional development was promoted in the department and we heard good examples from staff on the range of courses they had been able to attend. The department held ‘learning lunches’ to further support educational development. Several of the radiography staff were taking post graduate courses. There was a progressive culture around radiographer reporting with five reporting radiographers currently with two more planned in the near future. Two radiographers were also to be supported on the chest reporting course to increase reporting capacity of the team. The imaging department were seen to have effective clinical supervision and mentoring systems in place for radiology reporting staff.

Data supplied by the trust showed the overall appraisal rate for radiographers was 73.4% in September 2017 against a trust target of 80%. The staff we spoke with had all completed their appraisals and told us they were able to identify specific learning through the appraisal process and were encouraged to develop their professional practice.

**Multidisciplinary working**

There was good internal multidisciplinary team (MDT) working between specialties. Staff gave examples of other services using the fluoroscopy room such as the team looking at patients with swallowing difficulties. We observed good interactions on the phone between the teams.

Nurses, radiographers and doctors attended the audit meetings and a good team approach was evident throughout the inspection. The imaging department took part in other MDT meetings such as those related to cancer patients. One stop clinics were available in areas such as breast imaging. The orthopaedic clinics ran from Monday to Friday with open access to radiology.

**Seven-day services**

The department ran services over the whole week with extended hours, weekend sessions and on-call. CT ran appointments from Monday – Friday 8am-8pm with extra weekend sessions as required. The interventional service ran an on-call system after 5pm weekdays and at the weekends. The out of hours reporting service was outsourced to an external provider.

**Access to information**

The information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Staff told us and we saw they had access to trust policies and procedures on the intranet. X ray and diagnostic imaging results were available electronically via the picture archiving communication system (PACS) which made them promptly and readily accessible to staff.

The diagnostic imaging department supported the Image Exchange Portal (IEP) where images could be sent to and received from other hospitals.

Information was given to patients in their appointment letters about the type of x-ray test they were attending and any preparation required. Patients had discussions with the nursing staff in pre-assessment clinics to ensure they understood the procedure.

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

The staff we spoke with understood consent and the decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
Staff encouraged carers to escort their relative to appointments in order to offer support.
We saw examples of accurately completed consent forms. Patients we spoke with told us they knew what procedure they were having and that staff always asked for consent before proceeding.
Deprivation of liberty training data was not provided and was not available at the time of this report.

Is the service caring?

Compassionate care
All staff were kind, compassionate and caring in all the patient interactions we observed. There was a strong individual response from staff we spoke with about the department’s ethos to deliver patient centred care.

We spoke with six patients attending the department on the day of the inspection. There were no negative aspects of care highlighted to us. We were told that the staff were very kind and friendly. One patient told us they always had a good experience whenever they needed to attend x-ray. The department had recently introduced a feedback card. There were no results available for us to see but reception staff told us the patients were happy to complete the cards when asked.

The departments we visited were busy but the staff were seen to be competent, caring and ready to undertake the relevant examinations as requested.

Understanding and involvement of patients and those close to them
We spoke with one patient and their relative who said they were well informed about their care including the interventional radiology test they had just received. It was a fast track referral and they were happy with the process to date.

Emotional support
Patients told us staff were professional and supported them well. They considered their privacy and dignity had been maintained throughout their time in the department. We saw one assistant giving a patient an extra blanket as they were cold.

Staff had good awareness of patients with complex needs and gave examples of how they would deal with anxious or challenging behaviour.

Is the service responsive?

Service planning and delivery to meet the needs of local people
All of the diagnostic radiology areas had an established extended day, on-call and/or a seven day working pattern. This enabled patients to be seen at times to suit their needs.
Additional evening and weekend sessions were sometimes set up to manage any waiting lists caused by extra demand and equipment failure.

The emergency department had a designated x-ray facility situated on the ground floor. This area offered a 24 hour service specifically for ED.

Patients received clear appointment letters, explaining the purpose of their diagnostic test, what they needed to bring and how they needed to prepare. All of the patients we spoke with told us they received useful information to help them plan their visit.
Meeting people's individual needs

Staff were able to tell us of the support given for patients with a learning disability or dementia. There was access to interpreters for patients whose first language might not be English.

Separate male and female changing facilities were provided for patients. The department were able to accommodate patients in wheelchairs or in beds or those who needed specialist equipment.

The patient waiting areas were cramped and not particularly patient centred. The waiting area for accident and emergency x-ray was particularly small. The waiting areas in other parts of the department shared their space with large storage cabinets.

Staff used verbal announcements to inform patients of any delays with their appointment times and at particularly busy open access sessions.

Access and flow

Patients were referred to diagnostic imaging services by their GPs, hospital consultants and other practitioners such as nurse practitioners. All appointments were made by the administration team on the departments’ designated system. Patients could call and change the appointment if required.

Diagnostic imaging had seen a significant increase in demand over the last few years with the majority of the trust services dependent on radiology as a key diagnostic part of the patient’s pathway. The imaging department had seen growth of 38.3% in activity over the past decade at KCH.

Diagnostic waiting times (percent waiting six or more weeks)

Between 1 July 2016 and 30 June 2017 the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows six weeks plus percentages over time. Data provided by the hospital showed the hospital was performing better than the England average in July 2017 with the percentage of patients not seen within the six week target as 1.55%. The trust data showed the reporting figure for August diagnostic performance would be approximately 0.99%. This increase in performance was due to additional lists, outsourcing to the independent sector and a lower demand than normal. (DR69)
The reporting times by modality within 7 days at the time of the inspection were:

- CT 97.3%
- MRI 92%
- Nuclear Medicine 100%
- Ultrasound 97%

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral for the first two quarters. A dip below the average was then seen, with the trust recovering in quarter four. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within two weeks of an urgent GP referral (All cancers), King’s College Hospital NHS Foundation Trust

Learning from complaints and concerns

We reviewed the trust policy on the management of complaints and concerns. The policy detailed how to make a compliant and the procedure the hospital would follow to respond to it.

We reviewed the complaints for the KCH imaging department over the last three months. There were three complaints with one not upheld and two undergoing further investigation.

Patients gave mixed feedback about making a complaint. Some of the patients we spoke with were aware of the patient advice and liaison service (PALS).

Hospital data from PALS between June 2017 and August 2017 showed a total of 72 contacts as regards the KCH diagnostic imaging service. The top three issues for the initial complaints were around appointment delays and cancellations, communication issues and trust administration.

We saw complaints were reviewed and discussed at the monthly governance meetings. Staff told us the complaints and also any compliments were shared at the staff meetings. We saw minutes of meetings to confirm this.
Is the service well-led?

Leadership
At the time of our inspection, the diagnostic imaging services were managed with the Networked Care Division and in the care group incorporating critical care, radiology and medical engineering and physics.

There were new members of the senior executive team. These were slowly getting known to the staff but some staff told us they were not very visible. The Chief Nurse and Director of Estates were held in high regard by all we spoke with.

Local departmental managers were seen as visible, supportive and approachable by the staff. In recent months the department had undergone a large upheaval due to the removal of many of the radiology registrars in April 2017. Senior staff within the department told us it had been a very difficult time but robust plans had been put in place to manage this situation. They were very proud of their teams and how everyone had pulled together to make the necessary changes work for the good of the department and the patients they served.

Vision and Strategy
We spoke with the senior team about the vision and strategy for the department. We requested to see their strategy document but this was not received. The focus was on replacing imaging equipment to make the service more efficient and able to cope with increasing demand. There was also a renewed focus on the radiology training scheme. Each part of the scheme was now supported by a governing document to make the training needs and requirements explicit to all involved. The clinical director told us lessons had been learnt about training. Further work was to be undertaken with a team of organisational consultants specialising in the ‘human factors’ that impacted on an organisation’s ability to deliver and develop quality services. This was to involve 1:1 meetings with all consultant staff, superintendent radiographers, matron and the remaining specialist registrars. This strategy also involved a facilitated team development day and series of interventions and ongoing support.

We saw evidence that the department was proactive in the future planning and development of staff. This was particularly notable in the area of radiographer reporting and advanced practice.

The age of the imaging equipment had been a concern for many years and this was reflected on the risk register. Some new digital equipment had been installed and was in use and other equipment was in the process of installation. A business case was being prepared to move to a ‘managed equipment’ service which would allow the department access to the latest technology for a fixed annual fee.

Culture
All the staff we spoke with felt there was a positive working culture and a good sense of teamwork. Staff told us the department was very busy and they had needed to be flexible during many of the recent changes but that morale was overall good.

During our inspection the staff were friendly and willing to engage with the inspection. They demonstrated strong commitment to providing a good service for their patients. It was evident that quality and patient experience was seen as a priority for the service and was everyone’s
responsibility. Staff told us they felt involved and were keen to improve systems and processes to ensure patients received the best care.

Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly without any personal repercussions.

**Governance**

The diagnostic imaging service had a clear governance structure and regular meetings were being held to monitor and carefully govern the service. Staff were aware of these and participated in them such as undertaking risk assessments, audits and attendance at meetings.

We reviewed the last three sets of the monthly clinical governance meetings. These demonstrated there was oversight of the department’s risks, performance and key milestones. Governance processes were in place for radiation safety monitoring. There was a radiation protection committee (RPC) consisting of specialist staff across the diagnostic imaging disciplines that met on a quarterly basis. We looked at the latest sets of minutes for these meetings.

Daily ‘huddle’ meetings were held to review the overnight activity with specific regard to the outsourced radiology reporting service. We saw evidence of the daily emails sent to the senior managers of diagnostic imaging and the outsourced company to discuss any issues arising.

**Management of risk, issues and performance**

We noted the departments had risk registers and the risks that had been identified in our discussions were reflected on these registers. These included replacing radiology equipment and lack of staffing to meet the demand.

Vacancies for staff were all currently advertised and many of the vacant posts had been recruited to. There was a phased recruitment process in place. On the quality of the service received, for example increased waiting times in outpatients.

Audit systems were in place to measure the quality and accuracy of work carried out within the departments. This included audit days for staff to attend.

Staff were given feedback about incidents and lessons learned, comments, compliments and complaints. Communication mostly happened via email and the shared drive.

**Engagement**

The department collected feedback from patients. We saw the questionnaire on the reception desks. Staff were unable to tell us the direct result of any feedback but said there was a close relationship with PALS who would inform them of any issues.

Staff told us they enjoyed reading the trust magazine which was issues four times a year. It helped them keep up to date with new services, projects and latest research development as well as having a focus on staff and their achievements.

**Learning, continuous improvement and innovation**

The senior staff told us of development plans relating to equipment replacement, advanced practice and the revised registrar training scheme. We saw the approval to appoint a new role of ‘Delivery Manager’ to plan and organise weekly consultant timetable with prospective consultant cover for service activities and robust consultant supervision for all trainees. The administrator would also provide a local teaching programme and training administrative support.
The robustness of the policy and processes developed and embedded with the outsourcing company were confirmed during several recent major incidents. The team have recently been nominated for a Kings Commendation.

The department were proactive in training staff to meet the demands of the service, developing additional skills that would benefit patient flow through the hospital.

## Acute Services – Princess Royal University Hospital

### Facts and data about this service

Princess Royal University Hospital (PRUH) is part of King's College Hospital NHS Foundation Trust and is located at Farnborough Common, in the London Borough of Bromley. It serves a population of approximately 300,000 in Bromley and Bexley, and provides local services primarily for the people living in the London boroughs of Lambeth, Southwark, Bromley and Lewisham. The PRUH has 500 inpatient beds.

The Princess Royal University Hospital (PRUH) offers a range of local services including a 24 hour emergency department, medicine, surgery, paediatrics, maternity, critical care, and outpatient clinics.

## Urgent and Emergency Care

### Facts and data about this service

The emergency department (ED) at the Princess Royal University Hospital (PRUH) is open 24 hours a day seven days a week. It sees approximately 5500 patients per month with serious and life threatening emergencies and is also a Hyper Acute Stroke Unit (HASU).

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 18 years with approximately 900 attendances per month.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a nurse from a co-located urgent care centre (UCC) and, if determined suitable to be treated in the ED await triage (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). The UCC is managed by a different provider and was not part of the inspection.

The department has different areas where patients are treated depending on their needs, including a resuscitation area, two cubicle (majors) areas, and three 'sub-acute' cubicles for patients with less serious needs, and a clinical decision unit (CDU). A separate paediatric ED with its own waiting area, cubicles and CDU is within the department.

We visited the ED over two days during our unannounced inspection and returned unannounced during a weekday evening. We looked at all areas of the department and we observed care and treatment. We looked at 12 sets of patient records. We spoke with 30 members of staff, including nurses, doctors, allied health professionals, managers, support staff and ambulance crews. We also spoke with 16 patients and six relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

## Is the service safe?
Incidents

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between July 2016 and June 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between July 2016 and June 2017.

Of these, the most common type of incident reported was:

- Treatment delay meeting SI criteria with 8 (53% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 4 (27% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with 2 (13% of total incidents).
- Slips/trips/falls meeting SI criteria with 1 (7% of total incidents).

(Source: NHS Improvement - STEIS (01/07/2016 - 30/06/2017)

Of these serious incidents (SIs), three had occurred in the PRUH emergency department (ED). We saw the investigation reports from these and an incident report on the paediatric ED from August 2017. The incident reports were completed comprehensively and included action plans to check learning. However, we considered that some actions within these were not clear and were not established within timescales which reflected the gravity of the incidents. For example, one of the action points from the incident related to a meeting to improve communication between the paediatric ED and the paediatric ward team with a target date of 1 December 2017. The incident happened in August 2017 and therefore this reflected a lack of urgency around the need to resolve the underlying issues related to the incident. Staff in the ED told us that ‘similar’ incidents happened frequently and this meant there was no clear way to reflect how similar incidents had led to a resolution. Further examples related to two incidents where serious falls had occurred during the winter months in the ED. The action to audit the falls risk assessment was listed as
ongoing for the due date but did not start until June 2017. This meant that there was a long delay to identify areas to reduce the risk for patients.

All falls incidents in the ED were reviewed by the matrons who attended the hospital safer care forum to present the case and identify learning points to prevent further occurrences.

We found that nursing staff could demonstrate how to report incidents through the trust intranet and could discuss what type of incident they reported.

Between September 2016 and August 2017 the department had reported 635 incidents. Of those reported, 77 were listed as prevented or avoided harm, 474 were no harm, 70 were minor severity, 11 moderate, 1 major and two deaths. This indicated that the department had a positive approach to reporting incidents even when no harm had occurred in order that issues could be rectified and learning took place.

Incidents reported were graded on an investigation scale. All red and amber incidents had a root cause analysis (RCA) investigation, yellow had a local investigation and green were noted for monitoring themes. In the past year there had been 25 amber and red RCAs, 245 local investigations and 365 incidents noted for themes.

We attended the department governance meetings and saw that trends were being monitored and learning points and actions following incidents were identified. We observed that adverse incidents were shared from other parts of the trust and saw the department had developed changes to procedures to prevent similar incidents occurring in the ED. The department’s clinical lead attended the hospital risk and governance committee where all serious incidents were reviewed. Shared learning from these was then communicated within the department.

Over the previous two months leading up to our inspection, the highest trending incident theme reported was violence, aggression and security with 16 incidents reported in July and over 30 during August. This was much higher than the next closest theme of assessment, diagnosis, monitoring and review, which had eight incidents reported in July and 10 in August.

The trends and learning from adverse incidents were shared with the staff through a newsletter called “Tackling Risk in the ED”. This was published every two months on staff notice boards and emailed to all ED staff. We saw a recent copy of this newsletter on display. It contained learning points from case studies including the safe sedation of patients, assessment of a child with fever and communication considerations.

Staff told us that key learning from incidents was communicated during the handover, through emails or face to face as the practice development nurse and clinical practice facilitator walked round each day to catch up with staff. In addition we saw posters showing the ‘thought of the month’ which were put up to remind staff about key messages. The August thought of the month had been ‘If it isn’t documented, it didn’t happen’. The September thought was not yet displayed when we inspected.

We observed mortality and morbidity discussions at the governance meeting of all patients who had died in the department. Their treatment was considered to inform future practice and the learning was shared.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported no new hospital acquired pressure ulcers, no falls with harm and no new catheter urinary tract infections between 01 July 2016 and 31 July 2017 within urgent and emergency care. *(Source: Safety thermometer - Safety Thermometer)*

We noted at the inspection that safety aspects were not monitored in ED with the safety thermometer, instead a telephone application called ‘perfect ward’ was used. We saw the results of this displayed on the wall in the ED.

There had been an increased number of falls in the department since November 2016. The cause of this was considered to be department overcrowding, particularly over the winter. It had been identified that staff had not always completed fully the required patient falls risk assessments. A monthly audit had been started in June 2017 to monitor this. We saw the results of the first audit which showed compliance of the risk assessment completion at 76% with some clear actions identified, such as additional reminders and ongoing audit.

Laminated signs were visible in each cubicle to remind staff and patients of actions they could take to reduce the risk of falling. In addition a trial had been taken to provide leaflets to patients who attended the department as a result of a fall. The leaflet reflected information by the Chartered Society of Physiotherapy, and included a listing of six exercises for strength and balance. Positive feedback had been received from patients about the leaflet. A new falls risk assessment was planned as it had been found that the one being used was not best suited for the ED environment.

Within the initial assessment form were brief checklists to assess risk of falls and pressure ulcers of patients. On our unannounced visit we looked at the records of the three patients within the CDU and saw that although two of these had been completed, one for an elderly lady had only been partially filled in. Nursing staff told us that if patients were admitted to the CDU for an extended time then a nursing documentation form was completed which had a more thorough assessment for skin integrity, nutrition and bedrail assessments. They explained that they avoided prolonged stays for patients in the CDU and consequently they were not often used. We heard discussion within the clinical governance meeting that plans were being made for an extended care booklet to replace this that would be more appropriate for ED.

**Cleanliness, infection control and hygiene**

The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day. Stickers were used to denote if equipment in store rooms was clean. Nursing staff reported that regular staff were used which meant they were familiar with the layout of the department and the cleaning requirements.

Clean linen and equipment was stored in covered trolleys within the department and a sluice room provided a separate area for waste to be disposed of. Separate clinical and general waste bins were located throughout the department.

Chairs in the department were covered in plastic so that they could be cleaned easily. One chair in the waiting area had ripped fabric which could be a risk for infection. This had already been identified on the ward’s environmental audit and a repair requested.

One band 7 nurse and two band 6 nurses were designated as lead nurses for infection prevention and control. They were responsible for undertaking audits within the department and reminding staff about procedures.

Audits for hand washing were taken each week and showed that compliance with good practice was below the trust target of 95% for most of the last three months. However, compliance was generally above 90% and senior nurses told us how they were working on reminders for cleaning hands prior to patient contact as they had identified that this was a key area where they found staff to be non-compliant. During our visit we observed staff washing their hands and using hand gel appropriately. All clinical staff we saw were bare below the elbow. We raised the issue of a non-clinical staff member not being bare below the elbow while in a clinical area with senior nursing staff and this was addressed straight away.
There were 10 side rooms available for patients presenting with an infectious disease including an isolation suite. There had been an outbreak of Norovirus within the hospital wards in November 2016. The ED had identified patients with vomiting or diarrhoea using a form at triage. They had changed this to a sticker on the front of their notes to make it clearer a side room was required. If the patient needed admission the site team were advised so they could identify appropriate isolation. Personal protective equipment (PPE) including disposable aprons and gloves were available. There was access to hand washing facilities and hand cleaning gels throughout the department.

The toys in the children’s ED waiting room were cleaned every night to reduce the risk of infection.

**Environment and equipment**

There had been very few changes to the layout of the ED since our last inspection in 2015.

There was a waiting area at the front for patients waiting to see the triage nurse. This area was not visible from the ED reception desk, however could be viewed by receptionists from the co-located UCC. The adult triage cubicle was next to the waiting area so the triage nurse was able to view the patient’s each time they opened the door.

The waiting area was very open. Although some doors were access restricted other areas including the reception area were accessible from the waiting area by patients. Cameras were placed in the waiting room and could be viewed by security. However the ED reception was not visible on the cameras, which may pose a risk to patient and staff safety.

The ED had two main ‘majors’ areas for treating patients. In total there were 23 ‘majors’ cubicles, 10 of which were side rooms including an isolation room. The ‘majors’ area was where patients were accommodated within the ED who required a bed whilst having monitoring, assessments or investigations.

An area designated as used for the treatment of patients who did not require as close monitoring as those in the ‘major’s area. This had three trolleys and was available between midday and 10pm.

One cubicle in the ED was designated for patients with mental health needs requiring assessment or treatment. We were told this had been designed specifically with adjustments to prevent the patient harming themselves or others. There were two doors to the room that could not be locked from the inside or outside, a strip alarm around all walls and a ligature free sink which followed guidance. However we found there was no viewing panel to the room to help ensure the safety of patients by observing them and other necessary adjustments, for example, removing the cabling that may be a risk, had not taken place. This did not meet Royal College of Psychiatry best practice guidance. Although we were informed that patients were moved out of this room if it was needed for a vulnerable person, staff told us on inspection this did not always happen and they had to use whatever space was available for accommodation of vulnerable patients with mental health needs. We were told that if another cubicle had to be used for a vulnerable patient then all equipment such as suction and oxygen was removed prior to the patient being placed in it. We were told cubicles used were easily seen by all staff and curtains or doors kept open while the patient was unattended. In addition a risk assessment was carried out for patients attending with mental health needs and one to one care arranged if the patient was identified at risk of harming themselves.

Staff in the mental health liaison team told us they were not allocated specific space in the emergency department for assessment. This meant they had to use any available room to assess patients, including the family room. When this happened, these rooms were not available to other members of the public.
The department had a separate children’s ED. The department had four trolley bays, one cot cubicle, one high dependency cubicle, a minor injury bay, triage room and a two bed CDU. There was a separate children’s waiting area which had lots of play equipment for children attending.

The resuscitation area had four bays, one of which contained equipment suitable for acutely unwell children. Staff told us there had been a number of times when they had needed to expand the capacity of the resuscitation area to seven bays, due to the numbers of critical patients. They showed us an area where an additional two beds were placed and a cubicle opposite the resuscitation area provided the last space.

Staff told us that it could be challenging to treat critical patients in a crowded environment and senior staff in the department told us they wanted to increase the capacity of the resuscitation department permanently. We saw three incident reports which confirmed additional patients were treated in the room over and above the normal capacity. These reports highlighted issues with access to medications and maintaining patient dignity within the environment. Data seen on the inspection confirmed that the number of priority calls by the ambulance service had increased from 3972 in 2015 to 4365 in 2016, an increase of almost 10%. In the month of January 2017 there had been a 29% increase in priority calls from 386 in January 2016 to 499.

We were told that during the winter months there had been instances of ambulances having to wait with patients on trolleys due to overcrowding within the department. Nursing staff told us how these trolleys would be accommodated on the corridors in order to maintain a safe walkway for patients and staff.

A nine bed clinical decision unit (CDU) was adjacent to the department and staffed by the ED. This provided a short stay ward facility for patients awaiting test results or requiring overnight observation. This ward was also used to reduce late discharges home of elderly patients. In addition to the nine beds there was a seated area for patients waiting for blood results prior to discharge away from the ED.

A new telephone application called ‘perfect ward’ had started in June and included an environmental audit completed every seven weeks. We saw the latest results of the audit which was 91.7%. This showed significant improvement from the results in July which were 66.7%. An action plan showed issues needing attention and when they had been reported and resolved. Another audit undertaken was for equipment. The results of this were lower at 35.7% and showed there were a number of times when electrocardiogram leads were missing. This reflected what staff had told us. Senior staff told us they reminded those taking patients to the wards to retrieve the leads and they were also planning to buy some spares so they had sufficient for the expected rise in demand in winter.

We checked 10 items of electrical equipment within the department and found that all but three of these had been safety tested and serviced appropriately. These three items all had stickers on showing the due dates for testing had passed. Two monitors were due to have been tested in June 2017. One intravenous pump within a cubicle had a sticker which stated it was due a safety test in January 2015. We raised this with a member of staff to be checked.

The department had two equipment stores used for storing single use items of equipment. The store rooms were clean, tidy and well ordered. We checked 10 items of equipment randomly and found them all to be within their expiry dates indicating that stock control was well managed.

There was additional resuscitation equipment in the ‘majors’ department. This was clean and regularly checked. We found that all emergency drugs kept on the trolley were within the expiry dates and all equipment was appropriately stored.

**Medicines**

There was a designated pharmacist for the ED. The pharmacist carried out controlled drug (CD) audits and arranged for medicine restocks. Medicine audits were also completed by senior nurses as part of the ‘perfect ward’ telephone application. The latest results in August 2017 had been 76.7%. We were shown that actions identified from the audit had already been completed, for
example, moving the storage area of intravenous fluid bags from the floor to a more suitable location.

The medications room was secured with a keypad lock so was only accessible to authorised staff. We found one fridge unlocked during our inspection, although this was within a secure room. Senior nursing staff showed us where this had been highlighted as a broken lock on a recent check and showed it was waiting for repair.

We checked a random sample of medications stored in the fridge and found them to be in date. Maximum and minimum temperatures were appropriately recorded.

In the resuscitation area, some medications were stored in unlocked cupboards and fridges to allow access in emergencies. This was listed on the department risk register.

Controlled drugs (CD) were checked on a daily basis by staff working in the department. We randomly selected CDs from the cupboard to check against the CD registers and found they were correct. The CD register was generally well completed, however we found that wastage of CDs was not always recorded.

Patients’ allergy status was recorded in eight out of the nine records we reviewed. In addition we looked at three separate prescription charts and found medicine administration records were completed accurately in all of these.

At the last inspection we had found there was no fridge in the children’s ED for the medicines which meant that some topical creams were not stored appropriately. At this inspection we were told a fridge had been ordered but it was not suitable for medicines and therefore it was waiting to be changed.

**Records**

Patients were registered on the ED computer system which tracked the patient journey through the department and highlighted any delays. Those who accessed the department independently were initially registered on the UCC system and then had to re-register onto the ED system. We were told that it was planned there would be only one registration after November 2017 when the two computer systems linked. This record showed the time when patients were first registered onto the system, time of being seen by a clinician and when a decision to admit the patient had been taken. An additional field had been added so a brief plan could be documented which provided information about delays to admit or discharge patients.

Detailed clinical records were paper-based within the department. All healthcare professionals recorded care and treatment using the same document. A copy of these were sent with the patient to the ward if admitted and the record was then scanned and added to the computer system so it could be viewed if the patient was re-admitted.

Paper records were kept in a trolley within each ‘majors’ area or by the patient’s bed within the resuscitation room. Although these trolleys were kept unlocked for ease of access, they were next to the nurses’ station within the department and therefore a member of staff was able to identify if the records were being accessed inappropriately.

An electronic copy of the patient’s discharge summary was sent directly to the patient’s GP for those that were discharged directly from the department.

We reviewed 12 records from the ED ‘majors’ area, CDU and paediatric ED and identified that there was missing documentation in these. For example the doctor’s notes had inconsistent recording of the grades of doctors and time the patient was seen, with no general medical council (GMC) numbers recorded. There was no evidence of comfort rounding (a recommended approach in acute care for nurses to carry out regular check of a patient’s needs and pain at regular intervals), and limited completion of risk assessments such as falls and capacity. We raised this with senior nursing staff on the inspection who said they had not undertaken any in-depth audits of patients’ records due to time constraints. However, matrons reviewed some elements of patient records, including the national early warning system (NEWS), risk assessment and care plan.
completion on the quality ward round, and reported that they spoke directly to the member of staff if they noted an issue. We saw an example of a quality round form completed.

All clinical staff received mandatory training in health records keeping and nursing staff in the department were above the 80% trust target for completion of this.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:

Medical staff were underperforming against the trusts 80% target with an overall completion rate
of 46%. Nursing staff were exceeding the target at 90%. It was not explained why there was a 0% rate for Safeguarding Adults level 1. It was likely that this had been recorded incorrectly.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

All nursing staff within the department completed level three children’s safeguarding training. We saw records during the inspection which showed 97% of staff were within date for this.

Staff we spoke with in the children’s ED were aware of their responsibilities to protect vulnerable children. They were knowledgeable about safeguarding procedures. The children’s ED had a safeguarding flag system in place. Patients were checked against the Child Protection Register. Staff were not able to discharge children from the ED on the electronic system until they had completed a safeguarding prompt screen confirming there were no concerns about the child.

We observed good safeguarding practice with the management of a child under the age of two who had sustained a fracture. We were told the departments policy was all children under the age of two with any fracture or any injury sustained on a child who was not yet mobile had a senior paediatric doctor assess them to exclude any child protection issue.

Staff in the children’s ED had changed the system within the previous 18 months and 16 and 17 year olds were now triaged by a paediatric nurse. Prior to this staff had noticed the triage arrangements for this age group were unclear, and meant patients of this age group had not always received a safeguarding review. Staff told us this was a positive change as vulnerable patients were guaranteed to receive safeguarding assessments and support in an environment more suitable for them.

A senior paediatric nurse was the department link children safeguarding nurse. There was a children’s safeguarding lead for the trust who visited the children’s ED one day per week to attend the weekly Child Review Meeting, and support staff with any safeguarding queries for the remainder of the day. We were told a children’s safeguarding lead for the site was due to start in post in October, the month after our inspection. Out of hours safeguarding support was from the paediatric consultant or senior doctor.

The weekly child review meeting had a set agenda. The attendees were multidisciplinary and included representatives from child and adolescent mental health service (CAHMS), the head nurse from paediatrics, a paediatrician, safeguarding representative and the local young people’s service for drug and alcohol issues. The agenda was fixed and reviewed specific cases that presented to the department including all fractures in children under the age of two years, any cardiac arrests, and any poisonings. We saw the notes of five meetings which showed cases that had been discussed and identified whether a referral had been made to social services.

There was an adult’s safeguarding lead for the trust who could support staff with any safeguarding queries by telephone. They were new in post and told us a site lead was being advertised but had not yet been recruited.

Staff reported they had good relationships with the many local authorities in the area and we saw staff had access to the appropriate referral forms. These were emailed to a central team at the Denmark Hill hospital site and an acknowledgement was sent confirming receipt.

Mandatory training

The trust set a target of 80% for completion of mandatory training. A breakdown of compliance for mandatory courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:
Mandatory Training PRUH Medical Pt. 1

- Fire: 82%
- Infection Control (Clinical): 65%
- Aseptic, Non Touch Technique: 60%
- Bullying and Harassment: 44%
- Health and Safety: 40%
- Blood Transfusion: 29%
- Conflict Resolution: 23%
- Violence: 23%
- Dementia: 11%
- Information Governance: 11%
- Health Record Keeping: 5%
- Medicines Management: 5%
- Consent: 0%

Mandatory Training PRUH Medical Pt. 2

- Slip Trips and Falls: 83%
- Hand Transfusion (Clinical): 73%
- Venous Thromboembolism: 69%
- Safeguarding: 63%
- Adult Level 1: 50%
- Resuscitation: 44%
- Children Level 2: 44%
- Safeguarding: 24%
- Mental Capacity: 24%
- Prevention: 20%
- Safeguarding: 20%
- Safer: 0%
Medical staff mandatory training was performing below the trust target of 80%, with a completion rate of 50%. The nursing area was performing above target with a completion rate of 84%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training was either undertaken as face to face or e-learning. The face to face training included Mental Health, safeguarding adults, fire safety, infection prevention and control, and blood transfusions. All of these modules could be completed as e-learning if staff were unable to attend the face to face sessions.

We saw records during the inspection which showed out of the 13 mandatory training modules 11 were over the trust target of 80% completion for nursing staff. The two which were below the target were falls e-learning at 64% and venous thromboembolism at 51%. We were told that staff could complete these on e-learning.
Immediate life support (ILS) was completed as part of clinical core skill days, which were held as face to face training at the Kings College Hospital (KCH). We were told these days were difficult to access as they were booked up extremely quickly when they were advertised as available. However, the department had set up a one day in-house course with the resuscitation officer and now 80% of the nursing staff were in date for ILS.

**Assessing and responding to patient risk**

Patients accessed the ED independently or by ambulance.

Patients accessing the ED independently registered at the co-located Urgent Care Centre (UCC) and were seen by a nurse who carried out an initial clinical assessment (streaming). Patients assessed as requiring ED treatment then re-registered at the ED reception and were seen by a triage nurse. The UCC was managed by a different provider. The UCC had been inspected by the CQC in February 2017 and rated overall as ‘Good’.

Ambulance patients were taken into a separate entrance to the resuscitation area if they required immediate treatment and others to a ‘handover’ nurse for assessment and allocation of treatment area. The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment so a team was waiting for them on arrival. Ambulance staff pre-alerted the department of patients who required access to the HASU for acute stroke and a specialist team was contacted to meet the ambulance crew in the resuscitation area and arrange assessment and treatment straight away.

Children who did not attend by ambulance were seen for an initial assessment by the UCC and if they required ED treatment directed to the children’s ED where triage was undertaken by a paediatric nurse.

The records reviewed in the ED and CDU used the National Early Warning Score (NEWS) system to detect deterioration in adult patients and all records we looked at had completed NEWS sections. The children’s department used an age appropriate paediatric early warning score to assess deterioration and all five records we viewed had this completed.

Sepsis was a focus of the hospital. The ED had a sepsis screening box on the front of initial assessment forms that was completed at triage or ambulance handover. Two boxes containing the sepsis six equipment were available for easy access within the department.

Patients attending with mental health had a risk assessment carried out to identify the level of risk the patient presented to themselves or others. From this, actions were taken such as asking Security officers to attend or booking registered mental health nurses (RMN). The use of medication was also considered. We saw a blank copy of the child and young person risk assessment and the observation form that would be used.

The designated consultant for the CDU reviewed all ‘red dot x-rays’ on a daily basis. A ‘red dot x-ray’ was when a radiographer marked all abnormal x-rays with a red dot. This indicated that all abnormalities had been recognised and acted upon and that communication with the patient’s GP had been made. If any of these areas were not completed then the CDU consultant contacted the patient and GP to arrange the next steps. This reduced the risk of x-rays being misinterpreted. The same checks were carried out for CT and MRI scans.

The designated CDU consultant reviewed the record of all patients that had not waited to be seen and risk assessed them for vulnerabilities and capacity. This provided excellent practice for patient safety.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment is no more than one hour. The standard over the entire 12 month period was reviewed between 01 July 2016 and 30 June 2017.

The trust had a mixed performance over the reporting period, although it did not perform in line
with the national standard at any point. August 2016 showed a marked improvement in the median time, November and December a marked decline. As of the end of the reporting period the median time was increasing, showing a gradual decline in performance.

**Ambulance – Time to initial assessment between July 2016 and June 2017 at King's College Hospital NHS Foundation Trust**

![Graph showing median time improvement and decline](source)

(Source: NHS DIGITAL: A&E quality indicators)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between May 2016 and June 2017 the trust reported 1212 “black breaches”, with a noticeable spike in the number of breaches over the winter months.

![Bar chart showing number of black breaches](source)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

During the current inspection at the PRUH we found there had been a change in the ambulance handover process for patients. A year ago, patients had waited an average of 25 to 30 minutes for handover, which was one of the longest times in London. We saw that a brief written handover was now taken by the nurse and a receptionist then registered the patient using the ambulance service paperwork. We saw data which showed the average length of time of waiting
had decreased. Of note was the July 2017 figure of 14.7 minutes, which was the best in London.

**Nursing staffing**

Kings College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fall below the trust’s target for a whole time equivalent (WTE) staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

Between June 2016 and May 2017, the trust reported a vacancy rate of 14% at the PRUH for qualified nursing and midwifery staff. This was higher than the target vacancy rate of 8%. There was some variation in the rate over a 12 month period, peaking at 16% in March and April 2017.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between June 2016 and May 2017, the trust reported an annual turnover rate of 15.3% with an average monthly turnover rate of 1.2% at the PRUH for qualified nursing and midwifery staff. This was lower than the trust’s target annual turnover rate of 20%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 3.3% at PRUH for qualified nursing and midwifery staff. This was higher than the trust’s target sickness rate of 3%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

During our inspection at the PRUH ED we found levels of nursing staffing had improved since our last inspection and there was less use of agency staff. We were told the department had only six nursing vacancies out of 100 whole time equivalents (WTE) as 12 new nursing staff were due to start. There had not been a staffing review since 2014 and we were told this was on hold until the new ED head of nursing was in post. The current ratio of nursing staff to patients was one nurse for every four patients.

Nursing staffing levels were clearly displayed within the ‘majors’ area of the department. Red identified if there were three or more gaps, yellow if there were two and green if one or no vacancies. On the day of our inspection it was identified as yellow. When there were gaps the nurse in charge or matrons would assist where required including cover for breaks.

We were told that band six nurse positions had been difficult to recruit to and so the department had over-recruited band five nurses and under the guidance of a clinical practice facilitator were supporting them to develop to senior roles. Senior nurses highlighted that there were no advanced nurse practitioner roles within the department and this made retention of experienced nurses difficult.

Nursing shift lengths were 12 hours with a night and day shift. An additional nurse was planned to support triage for six hours between midday and 6pm and 6pm to midnight; however, we were told this was not always filled.
Nursing handovers were planned at the beginning of each shift. We observed one handover on the day of our inspection. All nurses attended for the initial allocation session and key information or announcements were made. A more detailed handover then took place for each patient in the department between the nurse in charge for both shifts and the matron. During this time each nurse took a ‘bedside’ handover of patients in the areas they were allocated from the outgoing nurses.

Two nurses were planned to work within the resuscitation area where there were four bays. However we were told on a number of occasions additional patients required care in this area due to high demand and department overcrowding. This meant the nursing ratio for critically unwell patients was reduced and could mean that patients had to wait for nursing care. There were three incidents documented in the last year where this had been reported with concerns raised about the number of staff to be able to care safely for additional patients.

During the winter months an additional nurse had been arranged with bank or agency due to the increased number of patients. This additional nurse had been planned as a ‘corridor nurse’ to review, arrange diagnostic tests and treat those patients that were still on ambulance trolleys in the ED corridor waiting for a cubicle to become available. This spend had been analysed and a business case was being submitted to request the extra money required for the forthcoming winter.

Since the last inspection paramedics had been recruited as emergency care practitioners to work in the resuscitation area. There had been six recruited but only three were in post at the time of the inspection. We were told two more had been recruited and were due to start the month following our inspection.

ED associate technicians worked in the department providing 24 hour support to nurses. Their roles included taking bloods for tests and carrying out electrocardiograms for patients requiring cardiac assessment. We observed good teamwork between the triage nurse and technician when patients were initially assessed.

We were told of a change made since the last inspection related to patient handover between the department and wards. Instead of a nurse accompanying every patient a telephone handover was made to the wards for some. A checklist was used to identify which patients were suitable for this. This had reduced the number of times a nurse was needed to accompany a patient to the ward and therefore increased the availability of nursing staff to the department.

In the last inspection we found that children’s ED staffing levels did not always comply with the Royal College of Paediatrics and Child Health (RCPCH) guidelines as there were not always two trained children’s nurses on duty 24 hours, seven days a week. There were now 16 children’s nurses, and on the day and night there was always one senior children’s nurse and two junior nurses. Adult nurses occasionally assisted if there was an unfilled junior nurse shift. This meant the department was compliant with the guidelines. On the day of our inspection we were told there was only one vacancy and interviews for the post were happening at the end of the inspection week.

**Medical staffing**

The trust had reported their staffing numbers below for the period June 2016 to May 2017. These numbers fell below the trust’s target for a WTE staffing level of 2183.09 within the medical staff arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>1885.88</td>
<td>2090</td>
</tr>
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</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs
Vacancy rates
Between June 2016 and May 2017, the trust reported a vacancy rate of 20% in medical and dental staff at PRUH. This exceeded the trust's target vacancy rate of 8%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates
Between June 2016 and May 2017, the trust reported an annual turnover rate of 40% in medical and dental staff at PRUH. This exceeded the trust's target turnover rate of 20%. There was a significant spike in turnover in August 2016, where the rate was recorded at 19.8% for the month. This may indicate redundancies or the movement of a particular team to a new area. This in turn may have been a possible cause for the high turnover rate.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 2.5% at PRUH for medical and dental staff. This was lower than the trust's target sickness rate of 3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
The data supplied was incomplete and included inconsistencies. Due to this analysis has not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 95 whole time equivalent staff working in Urgent and Emergency Care at King's College Hospital NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Junior</td>
<td>27%</td>
<td>25%</td>
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(Source: NHS Digital Workforce Statistics)
Twelve WTE emergency medicine consultants provided on duty cover for the department between 8am and midnight daily with ‘on-call’ cover outside of these hours. Although there was one vacancy this was filled by a regular emergency medicine locum senior doctor who was ‘acting up’. Consultant rotas were planned around expected demand, for example two consultants were used for rapid assessment and transfer every weekday between midday and 5pm and an additional consultant planned for each Monday between 5pm and 10pm.

There was a shortage of middle grade doctors within the department. The rota planned for 12 WTE; however, there were currently four vacancies. This meant there were a number of shifts each month which needed to be filled by locum staff. In May 2017 there had been 161 shifts vacant and 45 of those remained unfilled. In July 2017 although the number of vacant shifts had increased to 183, only 30 remained unfilled. The department policy was that the middle grade overnight cover was never provided by a locum doctor and consultants reported they ‘acted down’ to ensure this post was covered.

Both junior doctor rotas for foundation year two and those on basic speciality training had 12 WTE each and there was one vacancy at the time of our inspection.

The trust was one of the pilot sites in the country for the medical training initiative. This was a national scheme designed to allow a small number of doctors to enter the country from overseas for 24 months before returning to their own countries with additional skills and experience. This scheme was supported by the academy of medical royal colleges and it was hoped that participation would help to cover vacancies.

In the children’s ED an allocated doctor was available from 8am – midnight seven days a week and in addition one or two paediatric doctors were allocated to the department between 10am and 10pm. Outside of these hours, doctors from the adult ED attended to see patients.

Medical handovers were planned at the beginning of the morning shift for all doctors starting at that time. We observed one handover on the day of our inspection. This included a review of patients in the department, an outline plan and any key actions that were required. A second handover took place at 4pm when the emergency physician in charge (EPIC) changed. We observed this on the day of our inspection and found it to be comprehensive with all patients discussed including specific vulnerabilities. In addition there was a staffing discussion highlighting any gaps and noting any locum cover.

**Major incident awareness and training**

The department had a major incident plan and associated action cards that were accessible to all staff. This plan provided clinical guidance and support to staff on treating patients in the event of a major incident. However, the plan was dated February 2015 with no date for a review so we were not assured it was up to date. A major incident cupboard stored designated equipment.

Senior staff reported that the hospital held regular exercises to test and train for a major incident. They told us one had happened in the previous week. They stated the trust used a simulation system for training in emergency management.

Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (CBRN). The CBRN plan was up to date with a clear review date documented as January 2018. Regular reviews of CBRN equipment and knowledge were undertaken by the local ambulance service hazardous area response team.

A business continuity plan contained action cards for potential interruptions to the service such as loss of oxygen, loss of phones and closure of the department. However the plan had no review date and had last been updated in 2015.

A short power outage occurred to one area of the department during our inspection. We observed all staff remained calm and there was clear leadership by nurses who assessed each area in a
methodical manner and confirmed that monitoring was still available for patients who were critically unwell. We saw staff reassuring patients and guiding them to other areas of the department that had not been affected. The disruption only lasted between five and ten minutes before power was fully restored.

There had been a reduction in the number of security staff in the hospital from six to four. This meant there were no longer dedicated staff based within the ED so security had to be called from around the hospital when required.

**Major incident training completion rates**

No training data pertaining to major incident awareness or training was available at the time of production of this report. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

<table>
<thead>
<tr>
<th>Is the service effective?</th>
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<tbody>
<tr>
<td><strong>Evidence-based care and treatment</strong></td>
</tr>
<tr>
<td>We looked at nine clinical policies on the ED shared drive and internal website. All of these policies were clearly based on NICE and other clinical guidance. Of these, six had a date of issue and four had a date for review. On two of the policies, the review date had been reached but the policy not been updated. We observed a doctor accessing clinical guidelines when they were treating a patient for a condition they had not treated previously. A senior staff nurse also told us of changes to care pathways including early analgesia and x-ray of patients presenting with hip pain before the medical examination in line with best practice guidelines.</td>
</tr>
<tr>
<td>The department undertook regular audits. These included national audits requested by the Royal College of Emergency Medicine (RCEM); others were based on the National Institute for Health and Care Excellence (NICE) guidance or considered other audits based on specific needs of the department such as chest pain. There was a consultant lead for audits and each audit had a junior doctor and nurse leading as a whole team approach. We saw results of some RCEM audits and have referred to these in patient outcomes. We also saw a list of the recently completed audits with actions that were planned to improve care and also a list of the next audits due to be undertaken, including a frailty audit and vital sign monitoring. This showed the department used audits in order to identify and develop improvements for patient care.</td>
</tr>
<tr>
<td>Audit discussion was a standing agenda item in the department clinical governance meeting. Actions from audits were shared via email with staff including non-clinical managers. A doctor told us &quot;management are supportive and responsive to audit outcomes.&quot;</td>
</tr>
<tr>
<td>We saw examples of care pathways completed for patients who had presented with specific conditions such as seizures. These pathways followed evidence based guidance for management and treatment of conditions.</td>
</tr>
<tr>
<td>We saw that ED paediatric team used PATHOS assessment tool when considering referrals for mental health assessment. PATHOS is a five question screening instrument used to identify high risk adolescents (13-18years) who present with overdose.</td>
</tr>
<tr>
<td>The older persons’ assessment liaison team used the frailty Rockwood score as part of the assessment of patients over the age of 75. Rockwood is a clinical frailty scale that is used to measure severity of frailty as part of a comprehensive geriatric assessment and is recommended by the British Geriatric Society Silverbook.</td>
</tr>
</tbody>
</table>

**Pain relief**

At the last inspection we saw the patient notes we reviewed did not demonstrate consistency with the recording of pain scores. On this inspection, we reviewed nine records and found seven out of the nine had no pain management documented. This could have meant these patients did not have pain; however this was not clearly stated.
At the last inspection we found the triage nurses had no patient group directives (PGD) in place to prescribe pain relief. This meant a delay as they had to request analgesia from a doctor. A PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. On this inspection we saw nurses and paramedics working within the department had access to PGDs for analgesia and this made the process quicker. Medications were not stored in the triage room but were stored close by so they could be obtained quickly.

We saw records which showed the pain management of six patients was reviewed most weeks as part of the matron’s quality round.

We observed staff asking patients if they were in any pain. One member of staff told us they felt pain management was very important in caring for patients and ensured this was not overlooked particularly for patients living with dementia.

The trust scored about the same as other trusts in the 2016 A&E survey for patients not having to wait too long to receive pain relief and for patients feeling that hospital staff did all they could to help control their pain.

**Nutrition and hydration**

Water was available in all areas of the department and we observed staff offering it to patients.

On the initial assessment form a section was completed to show if the patient had to remain nil by mouth in case of potential treatment.

Nursing staff showed us a nursing documentation form that was completed if patients were admitted to the CDU for an extended time. This form had charts for nutrition and fluid monitoring within it. No patients were being cared for on the CDU for an extended period during our inspection and we were therefore unable to see any completed sets of notes.

**Patient outcomes**

**Unplanned re-attendance rate within 7 days**

Between July 2016 and June 2017, the trust’s unplanned re-attendance rate to ED within seven days was generally worse than the national standard of 5% and generally worse than the England average. There was a trend of gradual improvement across the year. However this was very granular with an improvement of 0.6% from 10% to 9.4% at the end of the reporting period.

**Unplanned re-attendance rate within 7 days - King’s College Hospital NHS Foundation Trust**

(Source: NHS Digital - A&E quality)
However we saw data from the hospital that showed between April and August 2017 the unplanned re-attendance rate at the PRUH was between 3.5% and 4.8% which was better than the England average.

**RCEM Audit: Consultant sign off 2016/17**

In the 2016/17 RCEM audit for consultant sign off, the Princess Royal University Hospital was in the upper quartile compared to other hospitals for one of the three measures. The measure for which the site performed in the upper quartile was traumatic chest pain in patients aged 30 years or over (seen by a consultant).

We observed the results of the consultant sign off audit and planned actions being discussed in a clinical governance meeting. It was highlighted by the audit lead there were poorer results in the measure of abdominal pain in the elderly. Changes had been made to the computer tracking system so an extra column indicated if the consultant had confirmed sign off however it had been identified it was not being consistently used. Additional actions planned were a follow up safety audit. We saw this being written during our inspection.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 RCEM audit for severe sepsis and septic shock, the Princess Royal University Hospital was in the upper quartile compared to other hospitals for 3 of the 8 measures. The measures for which the site performed in the upper quartile were:

- Standard 4: Serum lactate measured: Within one hour of arrival – 78%
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival (82.9%)
- Standard 7: Antibiotics administered: Within one hour of arrival (74%)

Within the other five measures, PRUH performed in the middle quartile overall.

*(Source: Royal College of Emergency Medicine)*

**RCEM Audit: Asthma (2016/17)**

PRUH took part in the 2016/17 asthma audit. The hospitals had three out of 11 metrics in the bottom 25% of trusts, two out of 11 metrics were in the top 25% of trusts, with the rest performing in line with the middle 50% of trusts.

On our inspection we found that the asthma audit results had been an improvement from one completed two years previously in most indicators. We also saw actions planned following the latest results which included an asthma information leaflet to be given to patients on discharge to advise them of support available.


In the 2015/16 RCEM audit for vital signs in children, Princess Royal University Hospital was in the upper quartile compared to other trusts for one of the six measures and was in the lower quartile for two of the six measures.

The measure that performed in the upper quartile was:

Children with any recorded persistently abnormal vital signs who were subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

The measures that performed in the lower quartile were:
Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set.

(b) capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.

(Source: Royal College of Emergency Medicine)

RCEM Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast 2015/16

On the 2015/16 RCEM Audit for Lower Limb Immobilisation in Plaster Cast, Princess Royal University Hospital performed:

- In the lower quartile for the measure ‘If a need for thrombo-prophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, with a score of F in 0 cases. The sample size for this metric was given as zero, which may have indicated a data deficiency or failure to record.

- In the lower quartile for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 0% in 18 cases.

No other metrics were measured or recorded.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural Sedation in Adults (2015/16)

In the 2015/16 Procedural Sedation in Adults audit, Princess Royal University Hospital was in the upper quartile for two measures and the middle quartiles for the remaining five measures.

The measure(s) that performed in the upper quartile were:

- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities.

- Procedural sedation requires the presence of all of the below a) a doctor as seditionist, b) a second doctor, ENP or ANP as procedurist, c) a nurse

(Source: Royal College of Emergency Medicine)

The department submitted trauma cases for evaluation to the trauma audit and research network. The rates of survival at the hospital between January 1 2014 and March 31 2017 indicated an additional 1.5 survivors out of every 100 patients, which was a positive indicator.

Competent staff

The department had a practice development nurse (PDN) and had, in addition, introduced a new role of a clinical practice facilitator (CPF) to support nursing staff. This role had been created following the recruitment of a large number of newly qualified nurses to the department. We saw a competency pack for new nurses that they were required to complete to be signed off to work in specific areas of the department, such as the resuscitation room. New nurses also attended study days to learn how to undertake plaster application and triage.

The PDN and CPF arranged teaching sessions for all nurses and we saw a register of which nurses had completed the training, which included NEWS, medicines and falls. Staff also reported that scenario training was arranged in the department when the demand and workload allowed for it.

A paediatric practice facilitator supported the training and supervision of children’s nurses. Staff reported they were due to take on three newly qualified staff as they were now able to facilitate support for these nurses. Children’s nurses reported that they carried out training with the
paediatric ward staff and also the South Thames retrieval team who transferred unwell children. Recent subjects had included managing of children waiting transfers to paediatric intensive care.

The ED associate technicians were supported by the PDN. They had attended the nurse team training days in the past, and had requested a bespoke training day focused on their skill level. The first of these had been arranged for the month after our inspection.

Training was provided to all nursing staff around the presentation and management of mental health patients in team study days, which were planned four times a year. Mental health training was also included in the induction programme for all new nursing staff, along with a resource document which included the risk assessment tool and useful contact numbers and names.

A new role had been introduced within the hospital since the last inspection of nurse associate. This supported the development of a healthcare assistant to have advanced skills. We were told there was currently one post supported for in this role within ED.

Volunteers working in the ED were given training specific to the department needs. This included management of mental health patients and provided the ED with additional support for the nursing staff looking after vulnerable patients.

**Appraisal rates**

Between June 2016 and May 2017, 42% of overall staff at PRUH had received an appraisal compared to a trust target of 90%. Multiple entries within the data set had been left blank for number of appraisals carried out. This could indicate incomplete data recording of this material. It is possible this has caused the low percentage score within the site. A split by U&EC staff group at PRUH can be seen in the graph below:

![Appraisal Completion Rates - PRUH](Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We requested further information about the low levels of appraisals during the inspection. We were told the electronic appraisal system had just changed and this may have meant the full data was not available. The appraisal year ran from January to December 2017 and we saw records showing 75% of nursing appraisals had been completed up to the end of August.

Student nurses were supported in the department by a mentor and assistant mentor so they always had a nurse to approach for help and support. We saw a student orientation pack that they needed to complete.

Nurses expressed concern about the reduction in funding for education that had occurred each year. It was reported they were only allocated five places for the accident and emergency course each year, which was essential for junior nurses to complete. They had managed to bid for some extra places for this year but were concerned about availability in the future. The lack of funding
for courses was a key issue in retention of staff as some had left in order to take up opportunities offered elsewhere.

We spoke with a member of the security staff who described their regular conflict resolution training including physical restraint and verbal de-escalation skills. They told us they did not receive specific training for healthcare settings such as knowledge of Mental Health or dementia although they sometimes had to support staff in attending to these patients. However information provided by the hospital explained that the training security staff undertook included some information on challenging behaviour awareness such as clinical related factors, vulnerabilities and the complex needs of some patients with a focus on defusing, calming and resolving incidents.

The General Medical Council (GMC) trainee survey is a national review of the quality of medical education provided to doctors in training. Although a South London report had identified some outliers we reviewed the overall results in 2017 for the department and no outliers were identified, indicating the majority of doctors were satisfied with the support and training provided at the department. However, the department had identified that results were poorer amongst the senior doctors in training and had undertaken consultation with them to identify key issues. One result of this had been that the senior doctors felt they were having too much consultant supervision and therefore that level was now included in the rotation of Emergency Physician in Charge.

Every Wednesday dedicated teaching time was provided for junior doctors and consultants planned their rota so they could provide medical cover for the department to protect this time. We also observed a supportive response to a study leave request made by a junior doctor demonstrating the positive approach to learning and development.

**Multidisciplinary working**

Allied health professional including a physiotherapist and occupational therapist reviewed patients within the CDU each day in order to check referrals and facilitate discharges. Multidisciplinary (MDT) meetings were reported to be held as required to discuss complex cases.

Since the last inspection paramedics had been recruited to work within the resuscitation area as emergency care practitioners. This role was equivalent to the lead resus nurse. However the paramedics had additional skills, such as advanced airway management, which they were able to provide to patients. Staff we spoke with said the introduction of paramedics within the department had benefited all staff as it provided an opportunity for shared learning across the professions.

A fortnightly meeting was held with an officer from the local ambulance service in order to discuss performance, incidents and share information.

A monthly frequent attendees meeting was held within the department. We saw minutes of one of these meetings and saw they included a consultant and matron as well as professionals from other agencies, such as the local ambulance service, community matron and mental health trust. Within these meetings potential special case management for patients was discussed.

A psychiatric liaison team consisting of a team manager, 10 psychiatric liaison nurses and two consultants attended the department when requested if patients needed a mental health assessment or support. One consultant on the team was a specialist in older adults’ mental health. The team told us they provided some teaching sessions with new clinical staff to talk about mental health.

The ED had a link consultant who liaised regularly with the local mental health team. We were told the ED doctors had clear guidelines to support them in the treatment and management of mental health patients.

Paediatric mental health support was provided by the child and adolescent mental health services (CAMHS) team from the local MH trust. They were available between 9am and 5pm Monday to Friday. Out of hours support was provided by a duty psychiatrist who could access a CAMHS
specialist if necessary. A monthly meeting was held with CAMHS and involved the lead ED consultants and link nurse.

Every two months there was a meeting between the psychiatric liaison team, ED, local ambulance service and police, and the trust safeguarding lead to look at joint operational issues. A separate ED meeting was also held where issues specifically about incidents in the ED were discussed. It was reported that a lot of collaborative work with the ED took place.

**Seven-day services**

The department provided care to adults and children 24 hours a day, 365 days a year.

Medical staff reported they were able to access diagnostic scanning for patients quickly, and could approach Radiographers directly if they needed urgent access to results. CT scanning and x-ray facilities were located close to the ED and available 24 hours a day and mobile x-ray scanners were available to be brought in to the resuscitation area.

Nursing staff informed us they were able to access blood test results sent to the laboratory within one to one and a half hours on all days. A ‘hot lab’ within the ED provided staff with the ability to check blood gases immediately.

**Access to information**

A change to the process from paper and telephone to an electronic format for requesting blood results was due to take place. We observed a discussion of senior staff planning changes to the process ahead of the implantation of this system in order to ensure it happened smoothly.

Staff reported they were able to access policies and guidelines easily using the trust intranet. We observed information was communicated to staff in various forms including posters.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that between June 2016 and May 2017, Mental Capacity Act (MCA) training has been completed by 43% of ED medical staff and 80% of ED nursing staff within PRUH. The trust target was 80% which had been reached for the nursing staff however not for the medical staff.

(Source: Trust Routine Provider Information Return)

We saw that staff obtained consent from patients and parents appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved the patient. Staff could explain about deprivation of liberty safeguards (DoLS) of patients. They did say that DoLS was usually completed on the ward and was not common practice in the ED.

Staff we spoke with were able to describe how they assessed mental capacity and their management of the patient and escalation pathways if needed. We were told there was no exclusion criteria in ED and the psychiatric liaison team could be involved in second opinions where there were complex issues around mental capacity.

We saw the trust policy and consent form included reference to “Gillick competence”. This is when it is appropriate for consent to be obtained from a child under the age of 16 without the knowledge or authority of the parent. Training on the mental health and children’s act was included in Safeguarding children level 2. We saw data from the trust which showed that overall 83% of staff in the ED were compliant with this which was over the trust target.

One paediatric nurse we spoke with was able to explain the use of restraint and the MCA but not in relation to young people. They were not confident of the legal position of holding children or
young people in the department who did not wish to be there. However they told us they had called the legal team out of hours for immediate advice.

**Is the service caring?**

**Compassionate care**

During our inspection we saw and heard many examples of staff treating patients with compassion, dignity and respect.

We observed staff introducing themselves by name and explaining their roles to patients. Patients also confirmed this occurred.

We observed staff protecting the dignity of a patient who was being transferred from a trolley to a bed by placing screens around them and preventing other people from walking past. We also observed staff leaving a cubicle and drawing the curtains to allow a patient to undress in private.

The trust scored about the same as other trusts in the 2016 A&E survey for patients being given enough privacy during examinations and treatment and for patients feeling the doctor or nurse listened to what they had to say.

We spoke with 16 patients and several family members. All their experiences were positive. Patients described staff as “amazing”, “excellent both in the day and night” and “very pleasant.” One patient said staff had “done everything to help.”

A parent in the children’s ED told us that staff were “always very friendly and accommodating.”

We observed staff asking patients how they were feeling and asking whether they needed anything.

However we observed one instance where a doctor discharged a patient in the ED waiting area where confidential medical information could be overheard by others, which did not protect the privacy of the patient.

We saw many examples of compliments the department had received from patients about the kindness and good care shown to them. Cards received were put up on noticeboards within the staff room and department management offices and those named directly were emailed the details.

**Friends and Family test performance**

The trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally worse the England average between July 2016 and June 2017. The performance until January 2017 was poor, with some fluctuation but with an overall trend of decline. From January 2017 there was a marked improvement, a decline in May 2017 and then an extremely sharp improvement finishing out the reporting period above the England average. The difference between December 2016 and June 2017 was substantial, from 74.8% in December to 88.5% in June.

**ED Friends and Family Test Performance - King's College Hospital NHS Foundation Trust**
Data provided specifically for the PRUH unit showed that the performance of the ED was similar with the trust overall. Between September 2016 and August 2017 it had been between 71% and 88% satisfaction. (DR263)

Understanding and involvement of patients and those close to them

Patients and relatives told us they felt informed about the processes in the department and received regular updates on their care and treatment. One relative commented that “staff have been really good at keeping me informed.” Another patient told us, “staff have explained everything in a way that I can understand.”

Leaflets were available in the department to be given to patients being discharged from the ED on common conditions such as care after a road traffic collision and back injuries.

The trust scored about the same as other trusts in the 2016 A&E survey for giving patients the right amount of information about their condition or treatment and for being involved as much as they wanted to be in decisions about their care and treatment.

Emotional support

Staff we spoke with understood their role in providing emotional support to patients and their families. Staff told us they thought it was important to ask about a patient’s likes, dislikes and hobbies, with help from relatives where possible.

The trust scored about the same as other trusts in the 2016 A&E survey for patients being reassured by staff if feeling distressed and for patients feeling the doctor or nurse discussed any anxieties or fears they had about their condition or treatment.

We spoke to one patient who told us they had been worried about their symptoms but staff had reassured them and answered all their questions clearly.

We observed ED reception staff providing sympathetic and professional support to a distressed patient, including ordering food for their child.

We saw a volunteer providing emotional support to patients. Staff told us the volunteer attended the department regularly. A patient who had been supported by the volunteer whilst in the department told us the volunteer was “very kind.”

Relatives of patients who had died in the department were supported by staff. A chaplain was available to the department for emotional support if required. We were told that clothes were
provided to dress babies in after a death and handprints of the babies could be taken by the staff so parents would have these as memories.

Staff were supported after a traumatic event with urgent debrief sessions. The lead nurses for each team told us that they were aware of when staff were involved in a difficult situation and would follow up with them as required. Counselling services were available for staff to access as well as support from peers and senior staff.

Is the service responsive?

Service planning and delivery to meet the needs of local people

Staff reported to us the local community had a growing population with international backgrounds. A new screen was due to be added to the registration in the week after our inspection. This was planned to identify English language ability and identify if there was a need for a translator. However reception staff we spoke with were not sure if translators were automatically requested on the new system. Nursing staff could show us the account number of the translation service on the intranet and reported translators were accessible. They also told us some staff members were bi-lingual and could be used to translate where appropriate.

The paediatric ED shared a play specialist with the children’s ward. Play specialists worked with children to make sure the hospital environment was welcoming and fun and could provide distraction techniques when a child required a procedure that may be painful or upsetting. We saw a number of toys, stickers and DVDs designated for distraction available in the department.

There was no specific room designated for teenage patients in the children’s ED, however there were suitable DVDs for that age group and card games and a laptop available for their use.

Meeting people’s individual needs

A significant amount of attendees to the department were elderly patients. The ED had a Frailty Pathway in place designed for patients who were well enough to be discharged but needed additional support to reduce their risk of falls at home. The pathway provided ward-based Occupational Therapy and Physiotherapy. We observed therapy being provided by staff to patients in the CDU. Staff told us a community team provided support in the home once the patient was discharged. Staff identified patients who were suitable for the Frailty Pathway through nurse-led discussions, based on all available information about the patient. Staff told us this Pathway was frequently used in the ED.

The Frailty Pathway was overseen by a geriatric consultant and a frailty nurse specialist. These specialists had been operating in the department for 12 months. An older persons’ assessment liaison (OPAL) team had also been conducting virtual clinics since July 2017. The team reviewed elderly patients in the CDU and considered their treatment options in order to identify the most appropriate care plan for patients and reduce admissions where possible. Since the introduction of the OPAL 40 out of 70 patients who had been seen by the team were discharged from CDU.

The ED did not have a formalised process to support patients living with dementia. Staff were able to describe how they supported a patient but told us they did not have specific resources to use. For example, staff told us they took time to communicate with patients explained the layout of the department, provided newspapers or magazines to read, or talked to them about local landmarks they may recognise to help with confusion.

A new trust wide pilot to recruit volunteers over the age of 50 had started in June 2017. Some volunteers were given some training to support patients in the ED. We saw a list of clear ‘do’s and don’ts’ for the volunteers. Staff told us the volunteers were good for providing additional help and support to the unaccompanied elderly patients attending the department.
There was a trust-wide lead for learning disabilities who supported staff by providing advice, training and input. This was a role based at the KCH site and there was no local equivalent at the Princess Royal site. Some staff we spoke with were aware of the team and there was information about them on the trust intranet. However, this team specifically provided support and advice in relation to patients who were over 18. This meant that the specific advice and support for patients with learning disabilities under 18 may not have been covered.

During the day the department had a hostess service offering food and drinks to patients. This included hot food. At night nursing staff offered patients hot drinks and a vending machine was available within the department. Patients told us that staff regularly offered them food and drink and asked about their preferences.

Access and flow
The access system for patients attending the ED independently had not changed since the last inspection. Walk-in patients still needed to register at both the UCC and the ED reception if they needed to be treated in the ED. Nurses we spoke with described the system as ‘clunky’. Senior staff told us they were hoping an update to the ED computer system in November 2017 would mean the registration information could be transferred across the two computer systems being used. A pilot project of a triage form that the patient held had been trialled to reduce the amount of information the patient had to repeat. However it was found that it was inconsistently completed, and therefore was not a suitable option.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)
The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.
The trust did not meet the standard for a single month over the period 31 August 2016 and 31 July 2017.
The trust breached the standard 12 times between 31 August 2016 and 31 July 2017. Between 31 August 2016 and 31 July 2017 performance against this metric showed a trend of improvement.
The pattern displayed at the trust roughly followed that set by the England average. The December/January decline was far more pronounced at the trust, with a greater percentage fluctuation between best and worst performance throughout the year.

Four hour target performance - King's College Hospital NHS Foundation Trust

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<tr>
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<th>This Trust</th>
<th>England Avg.</th>
<th>Standard</th>
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At the last inspection we found that the hospital consistently failed to meet the target to see, treat and discharge 95% patients within four hours with the only 70.3% between January and December 2014. Although the hospital was still not meeting the target the overall percentage had improved and the hospital was meeting the trajectory set by the commissioners. The most recent data we viewed showed it was at 91% in July 2017 just above the England average of 90.3%.

Senior managers told us of the ‘whole hospital approach’ to improving patient flow and increase bed capacity since the last inspection. Clinicians we spoke with in the ED recognised this work had decreased the length of stays in ED, although told us the last winter had been very challenging. They commented that the hospital’s ability to recover after a busy day was much improved since the last inspection. For example, they would often only have one day of overcrowding in ED, rather than previously when overcrowding due to flow would last for a few days.

We were told patients could sometimes be referred to the ED from the UCC after seeing a clinical rather than directly following streaming. This could mean a ‘late referral’ after two hours, which left less time for the ED department to see, treat and discharge the patient within the four hour target. This was monitored by the department and data we saw on the inspection showed it was variable; however it was generally less than 10 patients in a day.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between August 2016 and July 2017. King's College Hospital NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Performance against this metric showed a trend of improvement. Despite a spike in December 2016 causing a pronounced decline in performance, PRUH rapidly recovered and in June 2017 was seen to be performing better than the England average.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - King’s College Hospital NHS Foundation Trust**
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from August 2016 and July 2017, 96 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in October 2016 and December 2016, and January 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2016</td>
<td>342</td>
<td>5</td>
</tr>
<tr>
<td>September 2016</td>
<td>765</td>
<td>2</td>
</tr>
<tr>
<td>October 2016</td>
<td>953</td>
<td>13</td>
</tr>
<tr>
<td>November 2016</td>
<td>1093</td>
<td>5</td>
</tr>
<tr>
<td>December 2016</td>
<td>1169</td>
<td>14</td>
</tr>
<tr>
<td>January 2017</td>
<td>1423</td>
<td>57</td>
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<tr>
<td>February 2017</td>
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</tr>
<tr>
<td>March 2017</td>
<td>822</td>
<td>0</td>
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<tr>
<td>April 2017</td>
<td>601</td>
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</tr>
<tr>
<td>May 2017</td>
<td>594</td>
<td>0</td>
</tr>
<tr>
<td>June 2017</td>
<td>470</td>
<td>0</td>
</tr>
<tr>
<td>July 2017</td>
<td>325</td>
<td>0</td>
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</table>

On our last inspection we found a significant amount of patients (782 over 12 months across the trust) had waited in the ED for 12 hours or more after a decision was made to admit (DTA). This had improved with only 96 patients across the trust waiting over 12 hours between August 2016 and July 2017.
The practice for the decision of DTA to be made by speciality teams and not by Emergency Medicine Consultants had not changed since the last inspection, with the exception of fractured hip patients that could be decided by the ED. Although this could mean a delay, staff we spoke with said there had been an improvement in the timeliness of assessment of patients by specialties.

We were told on the inspection there were times within the department when there was no space for patients due to lack of beds within the hospital. This led to overcrowding of the department. The resuscitation room had only four bays but we were shown where three extra trolleys and equipment could be accommodated if more was needed. The department did have an escalation and capacity management policy which had red, amber and green triggers for escalation and associated actions that needed to occur. The triggers included resus capacity of four, clinician wait times and cubicle availability. However, we spoke with two consultants who did not mention the policy or triggers when asked about managing overcrowding and they stated there were no accepted actions for managing escalation, and they re-arranged the department as necessary. Senior staff told us they did not divert ambulances if they were busy but did keep in contact with the local ambulance service on a regular basis to inform them of their capacity.

We were told on the inspection there could be times when capacity was restricted on the children’s ward leading to overcrowding in the children’s ED. This was not specifically on the risk register; however, operational flow throughout the hospital was. It was reported by staff there had been occasions when children had to have treatment in the corridor as the cubicles were full and the children’s waiting room was too full to manage well. We looked at incidents reported between September 2016 and August 2017 and found there had been three incidents logged when children had to be transferred to another hospital as there were no beds on the children’s ward and one date where two incidents logged as a long delay for assessment.

We observed a focus of the nurse in charge and other senior staff within the department on performance and awareness of patients who were due to ‘breach’ the four hour target. With this focus they were able to plan on moving these patients out of the department, however always ensuring this was done safely. Analysis of all breaches over the previous 24 hours was undertaken by the CDU consultant and common themes were identified and sent daily to consultants and managers across both hospital sites.

The hospital had bed management meetings four times a day to monitor the flow of patients across the hospital. We observed a bed meeting at lunch time during the inspection. There was representation from all wards and departments. The site capacity was graded as amber on this day. We found the meeting to be an efficient and effective overview of the capacity status. There was clear direction provided to identify patients suitable for the discharge lounge and facilitate forward planning.

Nursing staff took action to mitigate risks associated with long stays in the ED. Patients were transferred from trolleys onto beds and pressure relieving mattresses were available. However some nurses told us beds were not always available and they allocated to those with highest risk of pressure sores first.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

Performance has been consistently worse than the England average for the period of July 2016 to June 2017 with a higher proportion of patients leaving before being seen.

**Percentage of patient that left the trust without being seen - King’s College Hospital NHS Foundation Trust**

![Graph showing percentage comparison between this trust and England average.](image-url)
However we saw data from the hospital that showed that between April and August 2017 the percentage of patients that left before being seen was between 1.46% and 1.95% which meant that the PRUH site was better than the England average. (DR264 – in-bedded scorecard)

**Median total time in ED per patient (all patients)**

Between August 2016 and July 2017 the trust’s monthly median total time in ED for all patients was consistently higher the England average. Performance against this metric showed a trend of maintenance.

The median total time in ED had maintained over the past year. There was a small improvement in August 2016 and a small decline in December 2016. The rate held steady from February 2017 with very minor variation.

**Median total time in ED per patient - King’s College Hospital NHS Foundation Trust**

The paediatric ED had a separate CDU. Staff in the unit told us when patients came in with specific mental health needs they sometimes had extended waits in the CDU for a bed to become available. This meant the clinical decision unit was not available for other patients. The paediatric
CDU was next to the paediatric waiting area. There was no area in the ED identified as being appropriate for a patient who needed to have a low stimulation environment, for example, patients with autism spectrum disorders. This meant there was a risk that both the patients and other members of the public may be exposed to an inappropriate environment or increased risk due to the increasing disturbance created by a noisy environment.

Data provided by the trust showed that between August 2016 and August 2017, 23 patients between the ages of 12 and 17 had remained in the ED or paediatric CDU for over 12 hours. Most (16) had stays shorter than 24 hour, five between 24 and 48 hours and two were over 48 hours (77 and 189 hours respectively). Although this was listed as a high risk on the department risk register with the mitigation of having a registered mental health nurse with the patient, it was still an unsatisfactory arrangement for best care for these children and young people. One incident report we viewed stated that a young person had not had access to fresh air throughout their eight day stay.

A liaison general practitioner worked part time in the CDU to review patients and identify whether they could be better treated within the community. A pilot expanding this role to review patients after ED triage with a community matron had just started. This pilot had been supported by the clinical commissioning group (CCG) to reduce admissions; however, it was too new to identify any results yet.

Staff reported to us that the department had increased referrals to the ambulatory care unit since the last inspection. Patients attending the department in the day were referred by the ED consultant, and at night the senior doctor could refer patients to this service. Patients were provided with an information leaflet explaining the role of ambulatory care and the unit contacted the patient directly after their ED discharge to arrange a time when they should attend for assessment.

The CDU target length of stay was a maximum of 24 to 48 hours. However it was reported to us this was often exceeded due to bed pressures in the hospital. The CDU took medical outlier patients when there was no space in the medical wards, which impacted on capacity, flow and length of stay. It was reported that although there was an admission criteria for CDU, this was often ignored due to bed pressures. However all admissions to CDU had to be agreed by the consultant or senior doctor in the department for suitability.

Some patients could be referred to the local medical response team in the community. This team was able to support patients within their own homes, for example, by administering intravenous antibiotics in order to prevent unnecessary admission to the hospital.

**Learning from complaints and concerns**

**Summary of complaints**

Between June 2016 and June 2017 there were 44 complaints about the urgent and emergency services at the Princess Royal University Hospital. The trust took an average of 58 days to investigate and close complaints; this was not in line with their complaints policy, which stated complaints should be resolved within 25 days.

(Source: Trust Provider Information Request P55)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw data showing 62 complaints had been received by the department in 2016. The data from January 2017 to August 2017 showed there had been 41 complaints received so far in the year.

Patients or relatives who wanted to make a formal complaint were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service (PALS) who formally logged their complaint and attempted to
resolve their issue within a set period of time. An easy read complaints leaflet was available for patients with learning disabilities.

Formal complaints were investigated by a consultant or one of the matrons and replies were sent to PALS within an agreed time.

We observed complaints discussion during the monthly clinical governance meeting. We also saw previous minutes where seven complaints had been reviewed. Out of these three had been upheld or partially upheld, one was not upheld and the other two did not relate to ED issues and had been passed to other departments. Learning from these discussions was shared with the staff through the “Tackling Risk in the ED” newsletter, published every two months and available on staff notice boards or email.

Is the service well-led?

Leadership

There had been changes to the leadership structures of both the hospital and department since the last inspection. At the time of the last inspection executive leadership had covered both hospital sites and senior staff had reported this had proven difficult to engage with them. They told us at this inspection that having a dedicated senior site manager and site director of nursing was working much better and they were visible and approachable. An example was given when the site director of nursing came to the department during the winter when it was overcrowded. As well as taking actions within the hospital to manage the flow, she also assisted staff by caring for patients by taking them to the toilet in order to reduce the burden on the staff. Senior doctors told us the, "Atmosphere is much better since the change in senior management team at PRUH", and "management team are adaptable and ready to make changes."

Five new consultants had been recruited into the department over the last 18 months and it was recognised by clinical staff that support from the hospital human resource department had helped that to progress.

There had been a new post of ED deputy head of nursing at the last inspection. This post was vacant and had been changed to a head of nursing role for the ED. We were told interviews were planned for this position.

Since the last inspection the department had not had a permanent general manager. A number of reviews of the department flow had meant the interim managers had made changes but consultation had been limited and then these managers had moved on. It was reported to us by staff that the lack of stable management leadership meant it was difficult to drive change from within the department as there wasn’t a senior voice, and key management tasks such as preparation of business cases or review of nurse staffing requirements were not completed.

The local leadership of the clinical lead consultant and matrons was viewed extremely positively by all staff we spoke with.

Vision and Strategy

Senior staff we spoke with could not provide a clear written strategy for the department, however consistently told us about areas they wanted to improve for better patient care. These were to increase the resuscitation room capacity, improve the patient experience on arrival and have an improved paediatric CDU.

We saw all staff treated patients following the trust’s vision of excellence in patient care. Staff spoke about how their actions impacted on excellence in care for patients.

Culture
Staff we spoke with spoke highly of the team spirit and supportive atmosphere with the department. Staff praised the support given to them by senior clinicians and stated they felt able to raise issues when required.

Senior staff spoke highly of their staff within the department and praised them for their positive attitude to patient care, despite the department often being a challenging environment due to the numbers of patients that required care.

We saw that even when the department was busy, the culture within the department focussed on the needs and care of the patients to provide a good experience. Staff reported they felt confident to raise incidents and report any concerns they had.

**Governance**

Governance mechanisms were established in the department to monitor and improve standards of patient care. We observed a governance meeting and saw there was a core group of attendees, and others were also invited to attend. Complaints, incidents, audits and quality improvement projects were discussed. A governance teaching session was planned on Wednesdays for the junior doctors to attend but other professions were also welcomed.

The department had an additional quarterly trauma governance meeting. These were chaired by the lead consultant for trauma, who also worked at the KCH site on the Major Trauma rota. We were told of one outcome from this meeting had led to a discussion with a local race track who contracted private ambulance providers to provide treatment. These ambulances did not always follow the agreed trauma pathway for patients or call ahead to alert the department of a seriously injured patient. This had been communicated back and as a result had improved patients’ treatment.

Nursing staff did not work cross site and there were no joint ED governance meetings. However, the opportunity for shared governance or learning between the trust’s two ED sites was helped by having the same patient safety manager. Staff we spoke with commented that there were good informal links between the two departments’ staff.

Joint meetings were held with the co-located UCC once a month. This provided the opportunity for issues to be discussed and a solution reached. Staff we spoke with said that there was a good relationship with the UCC.

**Management of risk, issues and performance**

The ED maintained a risk register and we observed this being reviewed at the clinical governance meeting we attended on the day of our inspection. However the review dates for all risks had been April 2017. The two top risks were CAMHS patient care in paediatric ED and operational blockages in the PRUH admissions emergency pathway which could lead to ED overcrowding and may impact on patient safety. Mitigations were listed for these risks but as the risk register was not a standing agenda item within the clinical governance meeting, senior staff we spoke with could not tell us when it was usually reviewed. Two risks were proposed to be added during the meeting we observed. One was resuscitation capacity and the other was medical staffing. However the resuscitation room capacity was not a new issue suggesting that the risk and its mitigations had not been considered within an appropriate timescale.

Since the last inspection analysis of the department and flow within the trust had been undertaken by outside agencies to improve performance and decrease waits for patients. A ‘Here and Now’ transformation project had been started at the PRUH however we were informed by senior managers that this was now all focussed on the KCH site. We saw minutes of a recent project meeting, emergency flow board and the most recent highlight report that confirmed only the KCH site was the focus of this group. We were not informed of any methods of collaboration with the KCH site in order to identify methods of improving performance from this project.

However, despite interim managers and movement of the transformation project, there had been improvement made by the department in managing patient flow through the department since the
last inspection. This was demonstrated by the improvement in ambulance handover times and increased percentage of patients waiting less than four hours to be seen, treated and discharged.

**Engagement**

One of the key improvements in the department since the last inspection had been the changes made to the handover of ambulance patients, which had dramatically reduced the waiting times. This improvement had been identified by a member of nursing staff demonstrating a positive approach to staff engagement.

Public engagement was mainly obtained using the family and friends test. We were told that the department was increasing the numbers of patients proactively texted for a response as well as using cards although response rates were still low with between 50 and 212 responses per month over the last year. On this visit we saw that as part of the quality round that was attempted weekly, the matrons spoke to six patients each time and asked about their experience within the department.

**Learning, continuous improvement and innovation**

The department was involved in a pan-London collaboration to improve organ donation. This involved the identification of clinical triggers for suitable patients and the use of specialist staff to initiate discussions with family. This followed the NICE guidance on donor identification and referral.

The department used audits to continuously drive improvement within the department. We saw that clear actions were identified and re-audits planned following implementation of the actions for continuous improvement in patient care and governance processes.

A visit had taken place to another acute hospital in order to learn about how they used paramedics in the role of emergency care practitioners. Learning from this visit was being used to review and develop the new role and scope of clinical practice for this group.

**Medical care (including older people’s care)**

The medical service at Princess Royal University Hospital (PRUH) provided care and treatment for patients with cancers, blood disorders, strokes, cardiac medicine, respiratory issues and other conditions including care of frail and elderly people. There were 312 medical inpatient beds located across 16 wards, with day case beds located in an additional two wards.

The trust had 84,246 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 28,831 (34%), 6,187 (7%) were elective and the remaining 49,228 (59%) were day case. At the time of reporting figures relating only to the PRUH had not been provided.

Admissions for the top three medical specialties were:

- General Medicine – 30,883 admissions
- Clinical Haematology – 17,619 admissions
- Cardiology – 6,054 admissions

During our inspection we visited each of the medical wards and other wards where medical patients were receiving care. We spoke with a large number of staff in those areas including consultants, doctors, nurses, allied health professionals and ancillary staff. We spoke with 20 patients and reviewed 24 patient records and bedside patient notes. Before our inspection we held a number of engagement meetings at the hospital to which all staff were invited to attend.
**Is the service safe?**

**Incidents**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between May 2016 and May 2017, the trust reported no incidents classified as never events at the PRUH.

In accordance with the Serious Incident Framework 2015, the trust reported 35 serious incidents (SIs) in Medicine between 01 July 2016 and 30 June 2017 which met the reporting criteria set by NHS England. The trust wide figures are shown in the graph below.

Of these, the most common type of incident reported was:

- Slips/trips/falls meeting SI criteria with 12 (34% of total incidents).
- Treatment delay meeting SI criteria with seven (20% of total incidents).
- Pressure ulcer meeting SI criteria with seven (20% of total incidents).
- All other categories with four (11% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (9% of total incidents).
- Unauthorised absence meeting SI criteria with two (6% of total incidents).

(Source: Strategic Executive Information System (STEIS))

There were 17 serious incidents reported at the PRUH. The most common type of incident reported by the PRUH was slip/trips/falls. We reviewed SI data provided by the trust which showed from 1 April 2016 to 31 March 2017, there were 10 patient falls resulting in harm, four cases involving deteriorating patients, two hospital acquired pressure ulcers and one delay in treatment meeting the SI criteria. The STEIS and trust SI data provided show results over a different time period which accounts for a slight mismatch of figures although both datasets are correct.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff we spoke with told us they knew how to report incidents
and confirmed they received feedback either directly face to face from a manager or via email. The trust also had a newsletter on their intranet page called ‘SafetyNet’ which was used to highlight key safety messages to staff. For example we saw a ‘SafetyNet’ newsletter explaining ‘duty of candour’ and another describing an absconding patient incident and the lessons learned from the investigation.

From November 2014, registered persons were required to comply with the duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty, that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This means providers must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The staff we spoke with had a good understanding of duty of candour. Trust data reports state medical care services at the hospital have applied duty of candour principles 154 times in the year to May 2017.

**Safety thermometer**

The NHS Safety Thermometer is a national tool used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Patient harms recorded included new pressure ulcers, catheter associated urinary tract infections (CAUTIs), urinary tract infections (UTIs), falls with harm to patients over 70, and venous thromboembolism (VTE).

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

We found that the NHS Safety Thermometer information was available on each of the medical and elderly care wards that we visited. The information was updated monthly, and clearly displayed for patients, visitors and staff to see.

The safety thermometer will shortly be replaced at the hospital as it has been at the King’s College Hospital by ‘Perfect Wards’ This will be a weekly audit looking at a range of indicators such as infection, prevention and control; staffing; falls and pressure ulcers. This can be completed on a hand held computer device by each ward and provide the trust with up to date and live data of their performance. As a result of this transition phase the data we received regarding the safety thermometer criteria was incorrect.

**Cleanliness, infection control and hygiene**

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids.

All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

The hospital was cleaned by an outside contractor. We observed the housekeeping staff utilising the provided personal protection equipment correctly. We saw them wash their hands and use the hand hygiene gel.
There were housekeeping staff for cleaning wards and specialist medical units and cleaning staff understood cleaning frequency and standards.

All of the wards and specialist medical units of the hospital we inspected were visibly clean. Green ‘I am clean’ stickers were used to identify which equipment had been cleaned by staff and were ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned.

There was easy access to personal protective equipment (PPE). Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to handwashing and drying facilities. Services displayed signage prompting people to wash their hands and had guidance on good hand washing practice.

We observed staff regularly washing their hands and use the hand gel between ward bays and each patient. We saw staff adhered to the ‘bare below the elbows’ policy.

The hospital regularly undertook hand hygiene audits. The compliance trend was moving in a positive direction with an overall percentage in May 2017 of 93.6% against a trust target of 95%. In August 2017, the Acute Medical Unit 1 & 2 wards achieved 96% compliance.

Staff were knowledgeable about the principles and control measures used to prevent the spread of infection.

A patient we spoke with on medical ward 6 told us “Everything splendid and very clean, with the bedclothes and everything.”

Waste management, including those for contaminated and hazardous waste was in line with national standards.

There were no trust apportioned meticillin resistant Staphylococcus Aureus (MRSA) bacteraemia (presence of bacteria in the blood) at the hospital in the 2016/2017 reporting period. Trust apportioned refers to samples taken from patients four or more days after admission to the hospital. During the same period there were 19 trust apportioned cases of Clostridium difficile (C.diff), although after investigation it was decided no lapses of care had taken place. There were 25 trust apportioned cases of Escherichia coli (E.coli) reported and ten trust apportioned cases of Meticillin sensitive Staphylococcus Aureus (MSSA), two above the trusts target of eight.

**Environment and equipment**

The hospital was constructed under the public finance initiative (PFI) policy designed to use private financing to build and run public sector infrastructure projects. Staff told us any alterations or repairs took a long time to implement as approval was required and the cost was higher than in an NHS hospital funded by central government.

The general environment was bright, clean and modern but the lack of storage space meant equipment was often stored on the wards in the corridor areas. Such practice gave a cluttered appearance to some areas and the potential to create hazards and hamper free movement.

We checked the resuscitation trolleys on the wards and found all were properly sealed with plastic anti-tamper tags after checking the required equipment and medication was in place.

We saw sharps bins were available, correctly labelled, dated and below the maximum fill lines in all areas we inspected.
Housekeeping staff were seen to use personal protection equipment (PPE) such as disposable gloves and aprons as they went about their work. We saw appropriate change of PPE between areas, jobs and patients rooms. Clear signage was displayed when a floor was wet and presented a potential slip hazard.

Farnborough Ward consisted of 25 side rooms in a long, narrow corridor. The layout presented nursing staff with challenges regarding observation of patients requiring closer supervision such as those with dementia or at risk of falling. We were told patients were often switched around to accommodate the more vulnerable closer to the nurse’s station in the centre of the corridor.

On medical ward 8 there were four cardiac telemetry beds, although only one was working and the information was sent to the cardiac unit. A telemetry bed allows medical staff to constantly monitor patients heart rate, rhythm, breathing and other things and send the information to another location such as a nursing station or as in this case to a specialist unit.

**Medicines**

The hospital’s on-site pharmacy provided a pharmacist to each ward to provide advice, support and timely medication on discharge. The pharmacy had a two hour maximum prescription to delivery of medication turn around. However, some clinical staff cited the pharmacy as a source of patient discharge delay.

We spoke with the trust’s pharmacy lead who told us his vision of pharmacy within the trust was “one service many sites”. To that end the pre-registration pharmacy students rotated to all the trust’s sites and his plan was for the senior team to do the same. Pharmacy will have joint recruitment and joint training – recruited to the trust to work at any location.

The trust continued with its roll out of the electronic patient medicine administration (EPMA); which we were told would be implemented at the PRUH from October 2017.

We observed a pharmacist on the cardiac care ward. They were enthusiastic and had good interactions with the clinical staff.

We checked the drug cabinets which were all locked and within rooms secured by a keypad entry system. The keys for these cabinets were held by an allocated nurse, which was in line with trust policy. We did not find any out of date medication stock in the cabinets we checked.

We saw the controlled drug (CD) stock was checked by staff at the start of each shift and recorded in the CD register.

We saw medicines were stored in dedicated medicine fridges when needed; these were locked and the fridge temperature recorded. Checks of temperatures were recorded daily and fridge temperatures were recommended to be between two and eight degrees Celsius. Staff were able to explain to us what had to be done if the fridges went out of range.

During our inspection we observed staff give patients medication. Each time the patient’s wristband was checked in order to confirm the medication was given to the correct patient.

The trust used the ‘Safety Net’ newsletter system to alert staff to medication issues.

We were shown an example of the new style drug trolleys which had automatic locks and were expected to be on the wards by November 2017.
The electronic patient record system (EPR) currently used at the trust’s Denmark Hill site was expected to be fully functional at the PRUH by November 2017. We saw examples of the required computer hardware delivered to the wards in preparation. We were told one of the benefits of the new system would be staff would be able to check patient’s blood results during ward rounds to better inform clinical decisions.

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. The records were kept securely when not in use.

At the time of this inspection clinical staff used paper based documentation to record patient observation information, risk assessments and care plans. We found the completion of those patient’s notes was good on all of the medical wards visited.

We particularly looked at do not attempt cardiac pulmonary resuscitation (DNACPR) forms. We saw they were generally well completed and included capacity decisions and where necessary conversations with relatives were also documented. In the patient notes we reviewed where a DNACPR form was present it was the first document under the front cover to make sure staff were aware of the decision even in an emergency when non ward staff might attend. Electronic recording of DNACPR and treatment escalation plans (TEP) will be part of the EPR rollout.

On medical ward 6 we checked a selection of patient bedside notes. We found national early warning score (NEWS) observations and VTE assessments were documented. The drug charts recorded target saturations and we noted oxygen was prescribed as required in accordance with NICE guidelines.

Patient re-positioning charts were up to date, care plans and risk assessments were also completed correctly.

**Safeguarding**

The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:
Medical staff were underperforming against the trust's 80% target with an overall completion rate of 46%. Nursing staff were exceeding the target at 90%. It was not explained why there was a 0% rate for Safeguarding Adults level; this has been disregarded for these percentages. It is likely that this has been recorded incorrectly.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

During the period April 2016 to March 2017 trust staff across all locations made 645 adult safeguarding referrals and 1002 child safeguarding referrals.

Mandatory training

The trust set a target of 80% for completion of mandatory training. A breakdown of compliance for mandatory courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:
The medical staff arena was performing below the trust target of 80% completion of mandatory training, with a completion rate of 50%. The nursing was performing above target, with a completion rate of 84%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Assessing and responding to patient risk

The trust used the National early warning Score (NEWS) to provide a means of early recognition of deteriorating patients and provide the opportunity to escalate care. We saw good evidence of its correct use together with amended care plans and relevant escalation of care when required.

The hospital continued to operate a medical outreach team called iMobile, who were called when there were concerns about a patient’s condition. We found typically on the medical wards the iMobile team were contacted if the combined NEWS score was five or higher or if an individual parameter was three in line with the Royal College of Physicians guidance. The iMobile outreach team supported ward staff to care for deteriorating patients.

We noted patient VTE assessments on the medical units and wards were slightly above the trust’s 95% benchmark. During a ward round we observed a patient being risk assessed for VTE. The patient was prescribed prophylaxis in line with the hospital’s policy.

We observed a morning shift handover on a medical ward and heard patients being discussed with knowledge by the nursing staff. NEWS scores, ongoing care plans and arrangements for or delays with discharges were also discussed. Staff made individual notes and most knew the patients first name and details of their relatives if any.

We also observed a morning board round (staff gather by the white board on the ward displaying the patient details, consultants name and so on). It was well led by the ward consultant and attended by the matron, the ward manager, other nursing staff and therapy staff. We noted everyone was given the opportunity to contribute.

On the coronary care unit we noted there was no isolation room and staff informed us infectious patients were outsourced to other wards or nursed on the unit with precautions. This issue was on
the hospital’s medical risk register which showed some implemented measures to mitigate the potential problem. It was last reviewed on 29 June 2017.

**Patient moves per admission**

Between May 2016 and May 2017, 72% of individuals did not move wards during their admission, and 28% moved once or more. We did not have information relating to any moves during night time hours.

**Nursing staffing**

Staffing has remained an issue at the PRUH despite active recruiting by the trust. One ward manager on a specialist medical unit told us they had 12 vacancies. Other wards also carried vacancies. This was not to say the level of nursing care was unsafe as the permanent staff were supplemented by bank staff, usually staff who had worked on the same wards for some time and agency staff. Bank staff provided cover for planned and unplanned shortfalls in staffing, covering vacancies and staff absences as well as bringing specific required skills for short periods of time. King’s Bank hires temporary/bank staff in partnership with NHS Professionals and cover all staff groups including doctors, nurses, midwives, HCAs, allied health professionals and other professional, scientific and therapeutic staff as well as admin and clerical, and project and management employees.

During our inspection we were told by a few ward managers they would have to step in and work shifts due to last minute staff sickness or the bank or agency staff not being available. We were told on one ward staff had agreed to attend training on their rest days rather than leave the ward short staffed. Staff were assured by their manager they would get the time back once staff levels improved.

A ward manager we spoke with told us the ward’s safe staffing levels were higher than the staff budget for that ward. The safe staffing level during the day was for five nurses and four health care assistants (HCA) yet the budget only provided for four nurses and two HCA’s. As a consequence the ward was over budget each month as the ward manager maintained the safe staffing levels. The same ward manager confirmed to us she was running with a 50% nursing staff vacancy.

The acute medical wards one and two should have had 120 staff on the rota, at the time of our inspection there was only 93 permanent staff.

Kings College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fall below the trusts target for a whole time equivalent (WTE) staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between June 2016 and May 2017, the trust reported a vacancy rate of 14% at the PRUH for qualified nursing and midwifery staff; this was higher than the trusts target vacancy rate of 8%. There was some variation in the rate over a 12 month period, peaking at 16% in March/April 2017 and dipping to 11% in November/December 2016.
Between June 2016 and May 2017, the trust reported an annual turnover rate of 15.3% with an average monthly turnover rate of 1.2% at the PRUH for qualified nursing and midwifery staff; this was lower than the trust’s target annual turnover rate of 20%.

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 3.3% at PRUH for qualified nursing and midwifery staff. This was higher than the trust’s target sickness rate of 3%.

Bank and agency staff usage

The data supplied was incomplete and included inconsistencies. Due to this analysis has not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.

Medical staffing

We found similar staffing issues for consultants and doctors as we had for the nursing staff. A number of the consultants we spoke with were locum staff; some expecting to remain at the hospital for a few weeks others for many months. A locum is a person who temporarily fulfils the duties of another, literally a ‘place-holder’. Such places are usually filled by agencies under a national agreement with the NHS. Whilst the arrangement can ensure sufficient experienced and qualified staff are in post it can provide a lack of continuity for the permanent staff and long term patients.

Staff on Farnborough Ward told us they had not had a designated consultant for two months. The ward registrar told us he was always able to obtain consultant input when required. On the days of inspection there was a locum consultant but he was only going to be there for four weeks. Staff told us they did not know of any plan for after that time.

We spoke with junior doctor who was working as a member of the medical bank staff who told us the hospital had recently cut the bank rate which would mean an effective 25% pay cut. He felt it was a problem for the whole hospital and thought it may affect junior doctor staffing levels.

The Coronary Care Unit operated a ‘consultant of the week’ system which meant good consultant presence on the wards five days a week and weekends on call. However we were told the system affected outpatient clinics which then had less consultant cover.

The trust had reported their staffing numbers below for the period June 2016 to May 2017. These numbers fell below the trust’s target for a WTE staffing level of 2183.09 within the medical staff arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>1885.88</td>
<td>2090</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between June 2016 and May 2017, the trust reported a vacancy rate of 20% in medical and dental staff at PRUH. This exceeded the trust’s target vacancy rate of 8%.

Between June 2016 and May 2017, the trust reported an annual turnover rate of 40% and a monthly average rate of 3.4% in medical and dental staff at PRUH. This exceeded the trust’s target turnover rate of 20%. There was a significant spike in turnover in August 2016, where the
rate was recorded at 19.8% for the month. This may indicate redundancies or the movement of a particular team to a new area. This in turn may be a possible cause for the high turnover rate.

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 2.5% at PRUH for medical and dental staff. This was lower than the trust’s target sickness rate of 3%.

Bank and locum staff usage

The data supplied was incomplete and included inconsistencies. Due to this analysis has not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.

Staffing skill mix

Between 01 April 2017 and 30 April 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 511 whole time equivalent staff working in Medicine at King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: NHS Digital - Workforce statistics (01/04/2017 - 30/04/2017)

Major incident awareness and training

The hospital had its own major incident plan which was available on the trust’s intranet and was due for review in November 2017. It had been developed in conjunction with NHS England, Public Health England, local government and external emergency services.

Staff had access to action cards, serving as prompts to guide them on what to do in the event of a major incident.

Major incident/emergency planning awareness was part of the hospital’s induction program for staff.

Major incident training completion rates

No training data pertaining to major incident awareness or training was available at the time of production of this report.
Is the service effective?

Evidence-based care and treatment

The trust had introduced new posts of patient outcome leads who were responsible for ensuring the implementation of National Institute for Health and Care Excellence (NICE) guidance. As new NICE guidance was published it was then circulated to the relevant areas and a central record was kept of confirmation from the clinical lead that practice adheres to the guidance.

The hospital reported within medical care there were two derogations of NICE clinical guidance documents; CG153 Psoriasis: assessment and management, and CG144 Venous thromboembolic diseases: diagnosis, management and thrombophilia testing. The derogations were approved in September 2013 by the speciality’s clinical governance committee, ratified by the patient outcomes committee and monitored through clinical audit. Derogation is the act of officially stating a law or rule no longer needs to be obeyed.

Staff were able to access national guidelines and local policies through the trust’s intranet.

There was a sepsis pathway for staff to follow, where patient’s needs indicated that this was required. Sepsis, also known as blood poisoning, is the reaction to an infection in which the body attacks its own organs and tissues. While it can be life-threatening is can be easily treated if caught early. The hospital staff were using a bundle of six basic therapies known as ‘Sepsis 6’ to counter the infection. The electronic patient record system (EPR) which will roll out at the PRUH in the autumn of 2017 incorporates a sepsis 6 bundle tool. This will allow tracking of the bundle compliance in patients identified through screening as having high/red flag sepsis, severe sepsis or septic shock. The trust term this as ‘bad’ sepsis and following the EPS introduction at the Denmark Hill site inpatients identified by the i-mobile team who received antibiotics within 90 minutes has increased from low to mid 60% to 90% and higher.

During our inspection, we saw the trust did not have systems to ensure that patients who had been administered with rapid tranquillisation had robust physical health observations at hourly intervals as recommended by NICE guidance. Staff we spoke with on the ward were not aware of any trust wide policy to ensure that this took place. We saw incidents of rapid tranquillisation had taken place on Darwin Ward and medical ward 7 and there was no procedure in place in the trust to ensure that regular monitoring was completed by staff. Patients who have rapid tranquillisation may be at higher risk of side effects which have an impact on their physical health and the lack of a process or policy to carry out regular and frequent observations may mean that there is a risk of deterioration which is not responded to.

The latest NICE guidance as published in NICE Quality Statement 154, June 2017 states;
“...Rapid tranquillisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given rapid tranquillisation need to be monitored at least every hour until there are no further concerns about their physical status. If rapid tranquillisation is used while the person is in seclusion, additional measures may be needed to ensure safety. People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of rapid tranquillisation.”

We were sent a copy of the trust’s policy for the rapid tranquillisation of adults in the emergency department (ED). As the policy relates specifically to the ED it could explain why the ward staff we spoke with were unaware of such a policy. However, following our inspection we were told an
email was sent to all trust heads of nursing and clinical directors by the chief nurse and the medical director detailing the relevant NICE guidance. We have been assured from October 2017 the above will be included in the mandatory trust induction for all clinical staff and a module uploaded onto the new e learning platform, LEAP. A new trust wide policy, ‘guidelines for rapid tranquillisation’ has been produced which references relevant NICE guidance from 2005 and the NICE guidelines for the use of Rapid Tranquillisation (2017).

Pain relief
Patients told us their pain was generally well managed and they had received appropriate pain relief in a timely manner. One patient told us the pain relief was very good and given regularly. Staff increased the medication when it became ineffective and checked it had worked.

Assessments of patient’s pain was included in a routine set of observations. Patients were asked to rate the severity of their pain between one and 10. Those pain scores were recorded in patient’s records. We checked bedside records across all wards we visited and found pain scores completed for all patients.

Patients told us their pain was generally well managed and that they had received appropriate pain relief in a timely manner.

Nutrition and hydration
Patients who had difficulties with eating and drinking were referred to speech and language therapy (SALT) or occupational therapy (OT) for relevant assistance.

We saw patients were provided with jugs of water at their bedside. We noted consideration had been given with regard to placement of the jugs so as to be in easy reach. Some were only partly filled so less able patients were able to lift the jug to keep themselves hydrated.

Patient outcomes
The hospital defines patient outcomes as the results people care about most when seeking treatment, including longer life, symptom relief, quicker recovery and the ability to live normal, productive lives. The head of patient outcomes produced a regular staff newsletter titled ‘What matters most’ which provided the high-level headlines of the trust’s performance at a national level in relation to patient outcomes.

Between 01 March 2016 and 28 February 2017, patients at Princess Royal University Hospital had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in Clinical Haematology had a lower than expected risk of readmission for elective admissions
- Patients in General Medicine had a lower than expected risk of readmission for elective admissions
- Patients in Medical Oncology had a lower than expected risk of readmission for elective admissions
- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Stroke Medicine had a lower than expected risk of readmission for non-elective admissions
Patients in Geriatric Medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - *Princess Royal University Hospital*

Non-Elective Admissions - *Princess Royal University Hospital*

Sentinel Stroke National Audit Programme (SSNAP)

The Kings College NHS Trust took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, KCH achieved grade B in the latest audit on the 20th July 2017. A decline is visible across several of the Team-centred KI levels, most notably the stroke unit. Despite this, overall KCH has improved from its previous audit.

**Princess Royal University Hospital**

The Princess Royal University Hospital was assessed to make up part of the overall grading. PRUH performed well in many metrics with an overall level B; however the stroke unit continued to underperform at a level D. The speech and language therapy metric had seen a sharp decline from a level A to a level D. This indicated a significant change in this area over a year.

**Team-centred KI levels**

| 1) Scanning | A | A |
| 2) Stroke unit¹ | D | D |
| 3) Thrombolysis | B | B |
| 4) Specialist Assessments | B | B |
| 5) Occupational therapy | A | A |
| 6) Physiotherapy | A | A |
| 7) Speech and Language therapy | A | D |
| 8) MoT working | B | B |
| 9) Standards by discharge | B | A |
| 10) Discharge processes | A | A |

Team-centred SSNAP level (after adjustments) | A | B |
The stroke unit had shown a significant decline in performance against the SSNAP indicators from quarter two 2016/2017. It was recognised by the unit’s team who identified the reasons for the decline: in April 2016 the catchment area for the stroke unit was increased to cover additional postcodes which resulted in an additional 38 patient admissions (1354 bed days). There was an almost 20% increase in referrals from the Emergency Department, a 48% increase in discharge delays from the unit and delays in repatriating patients to their local units which should typically be no longer than 72 hours.

Having identified the reasons for the decline a recovery plan was agreed and implemented which had already increased the number of patients admitted to the stroke unit within four hours by 20% and almost halved the number of stroke unit outliers.

We visited the stroke and hyper acute stroke unit and found it to be well staffed, clean in appearance, spacious and well equipped. We observed an MDT meeting which was well attended by consultants, junior doctors, nursing physiotherapy and occupational therapy staff. The unit had achieved reductions in the rate of acquired pressure sores, falls and infections. The unit had four outliers on the day of inspection. Medical patients placed on non-medical wards because of a lack of bed space are referred to as outliers.

The stroke unit had 12 consultants providing a 24 hour, seven day service.

**In-hospital Care Scores**

Results for hospital in the 2015 Heart Failure Audit were similar to the England and Wales average for three of the four of the standards relating to in-hospital care. The hospital scored lower than the England average for input from specialist at 68.8% compared to the England average of 79%.

**Discharge Scores**

Results for King's PRUH were similar to the England and Wales average for five of the seven standards relating to discharge. Referral for cardiology rehabilitation scored lower than the England average.

**SOURCE:** NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

**National Diabetes Inpatient Audit**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributed a quartile to each metric which represented how each value compared to the England distribution for that audit year; quartile one means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.
The 2016 National Diabetes Inpatient Audit identified 65 inpatients with diabetes at Princess Royal University Hospital, 73.4% of patients with diabetes reported they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which placed this site in quartile one.
(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

Between April 2014 and March 2015, 97% of STEMI patients were admitted to a cardiac unit or ward at PRUH and 97% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.
The proportion of STEMI patients who were referred for or had angiography at PRUH was 68% compared to an England average of 79%.
(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 66%, which was worse than the audit minimum standard of 90%. The 2015 figure was 51%.
The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.4%, this is significantly worse than the national level. The 2015 figure was 19%.
The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 71.4%; this is slightly above the national level. The 2015 figure was 80%.
The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 78.9% this is significantly better than the national level. The 2015 figure was 57%
The one year relative survival rate for the trust in 2016 is 32%
(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust had a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.
The crude proportion of patients who had a vision assessment (if applicable) was 16% this is lower than the national aspirational standard of 100%.
The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 12.5% this is lower than the national aspirational standard of 100%.
The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 75% this is lower than the national aspirational standard of 100%.
The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 40% this is lower than the national aspirational standard of 100%.
(Source: Royal College of Physicians)
Competent staff

All new staff were inducted into the trust. The induction programme included the mandatory training staff needed to complete. It also included essential information such as the Kings values, trust aims and objectives, policies and procedures and information about health and safety.

All medicine staff were provided with a local induction in the workplace which helped introduce them to their area of work. There was a local induction checklist that needed to be completed. This covered key areas such as procedures, facilities, key contacts and risks etc. Bank and agency staff were also inducted onto the ward.

When the iMobile team were called to the wards we were told staff nurses shadowed them when able to increase their knowledge of practical assessments of unwell patients. On medical ward 6 we were told of healthcare assistants being iMobile trained.

We observed a phlebotomist introduce herself to a patient and take bloods using the aseptic non-touch technique.

The ward manager on medical ward 6 had introduced the ‘Big 3’ which she used to remind staff of the three current key issues or alerts. She had also introduced a safety briefing and encouraged the staff to talk about anyone unwell, any pressure sores, and to go through DNACPR and DoLS. When possible the briefing took place at a ‘safety huddle’ at 3pm each day.

A ward based junior doctor told us they had not been able to attend any training since they had started at the hospital a few months previous due to staff shortages.

Appraisal rates - PRUH

Between June 2016 and May 2017, 42% of staff at PRUH had received an appraisal compared to a trust target of 90%. Multiple entries within the data set had been left blank for number of appraisals carried out. This could indicate incomplete data recording of this material. It is possible this has caused the low percentage score within the site. A split by staff group can be seen in the graph below:

Appraisal Completion Rates - Medicine PRUH

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust have reported from the 2015/16 staff survey 73% of staff reported an appraisal in the last 12 months. The trust state the difference is a reflection of under recording on the current system.
The trust has made changes to their systems, focus and will incorporate the new learning management system LEAP. The new appraisal approach will be started in 2017/18 when all staff will have objectives for the year aligned to trust priorities and strategies.

**Multidisciplinary working**

We observed evidence of good multidisciplinary working across the medical division. We joined a few ward rounds, where the doctors, nurses and allied healthcare professionals met and discussed the care and treatment of each patient at the patient’s bedside. We noted that these were conducted in a respectful and professional manner, between all grades of staff and specialties.

We spoke with staff on the coronary care unit who told us they valued the discharge co-ordinator’s role. The discharge co-ordinator told us they received good back up from the unit’s medical staff and support from the community matron.

The frailty unit on medical ward 3 started a year ago. Patients were usually identified in the emergency department (ED) and the Acute Medical Unit (AMU) and once on the unit the patients were often ready to move on, either for discharge or to another ward, within ten days. A frailty specialist nurse was allocated to the unit and staff reported the whole team worked well together.

We observed a multidisciplinary team meeting (MDT) on the acute medical units. The meeting was attended by the consultant, junior doctors, nurses, an occupational therapist, an emergency medical technician and a band four technician. The meeting began with a few minutes of teaching by the consultant on consent and capacity. We were told training was included in the meetings whenever possible. Patients on both AMU one and two were discussed and all the staff were involved. The emergency medical technician attended the meetings to help identify patients that required scans to facilitate discharge.

Medical services had access to a social worker who helped facilitate patients discharge in a safe and timely way.

Cancer services operated on a MDT approach with regards to decisions around treatment. The MDT consisted of a range of specialists from across the oncology pathway and partners from the cancer centre.

**Seven-day services**

The service provided patient care seven days a week throughout the year.

The iMobile team was available seven days a week 24 hours a day to assess and provide support for deteriorating patients on wards.

Speech and language therapists (SALT) and dietitians were available Monday to Friday.

Occupational therapists and physiotherapists were available Monday to Friday and there was a limited physiotherapy service available on weekends.

**Health promotion**

During our inspection we saw a range of health promotion leaflets on medical wards which supported national priorities. The leaflets offered information and advice for those living with dementia, promoting the benefits of stopping smoking and information regarding drinking too much alcohol.

**Access to information**
Staff were able to access the trust’s intranet via readily available computer terminals. It gave them access to all of the policies and guidance documents as well as newsletters such as ‘Safety Net’.

The new e-learning system LEAP will also be available via the same computers as well as the staff’s own mobile devices.

Wards displayed safety thermometer information regarding staffing levels and other details relevant to staff, patients and visitors. This will soon be replaced by ‘perfect ward’.

Staff we spoke with told us they had not encountered any issues with the availability of medical records.

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

The trust reported that between June 2016 and May 2017, Mental Capacity Act (MCA) training has been completed by 75% of eligible staff in within Princess Royal University Hospital. A breakdown by specialisation within Medicine is displayed below.

Data around provision of deprivation of liberty training was not provided and was not available at the time of this report.

![Mental Health Training - PRUH](image)

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff on the medical wards at the hospital made 17 deprivations of liberty safeguards (DoLS) applications between June 2016 and May 2017, of which five were approved.

The hospital did not have a dedicated adult safeguarding and mental capacity lead at the time of our inspection, although this was something the team were addressing. This meant staff on site did not have access to immediate support, although they were supposed to access the team at KCH. Two nurses we spoke with told us that the adult safeguarding team was not consistently responsive when they sent requests for deprivation of liberty safeguards authorisations. On Darwin, we saw one request for an assessment for a standard authorisation had been delayed and the ward had been advised to seek a two week extension to the initial urgent authorisation which they had completed themselves. It was not clear in the patient records why this additional time was needed.

We saw some examples of comprehensive mental capacity assessments on Darwin Ward (a surgical ward with some medical patients as outliers) where reasons for decisions made about capacity and the decision which they related to were explained by the doctor who had been involved. These assessments demonstrated a comprehensive understanding of the Mental Capacity Act. On Darwin, we also saw that, when necessary, referrals had been made to the local
authority, through the trust safeguarding team for assessments for the authorisation of deprivation of liberty safeguards orders.

There was a trust wide lead for learning disabilities that supported staff by providing advice, training and input. This was a role which was based at the KCH site and there was no local equivalent at the Princess Royal site. Some staff we spoke with were aware of the team and there was information about them on the trust intranet. However, this team specifically provided support and advice in relation to patients who were over 18. This meant that the specific advice and support for patients with learning disabilities under 18 may not have been covered.

Is the service caring?

Compassionate care

The Friends and Family Test response rate for Medicine at the trust was 30% which was better than the England average of 25% between 01 July 2016 and 30 June 2017. Despite this, the response rate at PRUH averages at 23% which is below the England average.

**Friends and family Test – Response rate between 01/07/2016 and 30/06/2017 by site.**

![Image of Friends and Family Test chart]

The below table breaks down the friends and family test on a ward by ward basis across Princess Royal University Hospital:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp.</th>
<th>Resp. Rate</th>
<th>May -16</th>
<th>Jun -16</th>
<th>Jul -16</th>
<th>Aug -16</th>
<th>Sep -16</th>
<th>Oct -16</th>
<th>Nov -16</th>
<th>Dec -16</th>
<th>Jan -17</th>
<th>Feb -17</th>
<th>Mar -17</th>
<th>Apr -17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farnborough Ward</td>
<td>101</td>
<td>24%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>93%</td>
<td>100%</td>
<td>95%</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Medical Ward 2</td>
<td>119</td>
<td>26%</td>
<td>0%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>92%</td>
<td>84%</td>
<td>83%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Medical Ward 4</td>
<td>139</td>
<td>31%</td>
<td>93%</td>
<td>0%</td>
<td>80%</td>
<td>30%</td>
<td>0%</td>
<td>71%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>91%</td>
<td>97%</td>
<td>53%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

On medical ward 4 we saw one of the HCA’s playing a board game with a patient, another member of staff told us the HCA was washing a patient’s hair earlier. Patients told us the HCA would do patients hair and nails for the female patients who request it. We were told later she bought the polish and other sundries herself.

On medical ward 7 we saw lunch delivered and observed two members of staff who helped patients to eat. The staff cleaned their hands and helped the patients to sit up before they assisted
them to eat their meal. They did not rush them and both checked the patient liked the food and offered condiments.

In the hospital’s café in the main reception area we observed a member of the housekeeping staff who helped a woman with a pushchair and child in arms by offering to carry her tray to a table.

Overall feedback from patients we spoke with was very positive; all said they received good personal hygiene care. One patient said, “Staff here are lovely with gentle personalities, doing everything they can, but the days when they had the time to sit and talk with you are gone.”

Most of the patients we spoke with told us a doctor came to see them every day, a few felt they did not see the doctors enough.

One patient told us he had an argument with a nurse who had been impatient with him over his use of a commode. He told us he hadn’t spoken to her (the nurse) since.

We saw nursing staff taking and recording observations and demonstrating good interpersonal skills. Similarly, when staff gave patients ‘bed baths’ we heard they gave instructions about what they would like them to do and waited patiently for them to move.

Patients we saw on the wards appeared to be well cared for. Those who were unable to properly take care of themselves were properly dressed so as to maintain their dignity.

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

On medical ward 6 we observed a consultant communicating with a deaf patient by writing down what he needed the patient to understand. With another patient the consultant bent down so his head was level with that of the patient so he was not looming over him.

Patients told us they were spoken to about their care and what was going to happen and why, although one patient said, “doctors say they are going to do tests and then you have to wait a long time before anything happens. They also change their minds a lot.”

A patient we spoke with in the discharge lounge said she had seen the consultant after the scan and their discharge had been discussed with them.

**Emotional support**

Patients received emotional support from various sources during their stay in the hospital.

There were specialist nurses available to offer support, counselling and advice for patients with many of the long-term conditions on the wards.

The trust employed a wide range of clinical nurse specialists who supported patients and their families with specific needs and long-term conditions; they included oncology, respiratory, tissue viability and diabetes nurses.

The Chaplaincy team at the PRUH offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. Services were held each day of the week.

**Is the service responsive?**

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

In relation to the PRUH the trust liaised with Healthwatch Bromley, Lewisham, Lambeth and Southwark, in addition to Bromley Clinical Commissioning Group (CGC). They invited comment on future plans and strategies.
Between 01 April 2016 and 31 March 2017 the average length of stay for medical elective patients at Princess Royal University Hospital was 1.2 days, which was lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.3 days, which was higher than England average of 6.7 days.

- Average length of stay for elective patients in Pain Management was lower than the England average.
- Average length of stay for elective patients in General Medicine was lower than the England average.
- Average length of stay for elective patients in Cardiology was higher than the England average.
- Average length of stay for non-elective patients in General Medicine was higher than the England average.
- Average length of stay for non-elective patients in Stroke Medicine was lower than the England average.
- Average length of stay for non-elective patients in Cardiology was higher than the England average.

**Elective Average Length of Stay - Princess Royal University Hospital**

![Elective Length of Stay Chart](image)

**Non-Elective Average Length of Stay - Princess Royal University Hospital**

![Non-Elective Length of Stay Chart](image)

*(Source: Hospital episode statistics)*

**Meeting people's individual needs**

We saw signs above patient’s beds to indicate the patient used a red tray together with speech and language therapist’s instructions. Red trays and related signage was used to indicate the patient had high level needs such as dementia.

Mealtime champions had also been introduced and unless other duties were more pressing nurses were expected to get involved with patients mealtimes to help those who found the act of eating more difficult than others.
We saw patients were referred to specialist nursing services when appropriate. We heard discussion about such referrals taking place during board rounds and saw such referrals in patient notes. For example, we saw patients had been referred to the tissue viability nurse (TVN) regarding pressure ulcers and other patients had been referred to the iMobile team for escalation of care.

The Acute Medical Unit had been refurbished to suit the needs of patients with dementia. Bright colours had been used to differentiate doors from the walls and the wash basin areas were bright orange.

Patients we spoke with were generally complimentary about the food they received. However, one patient told us, “With supper at five and breakfast at nine it’s a long gap. If you ask for a snack they will give you something if there’s anything in the fridge.” Another said, “I’m unhappy about the choice at breakfast, cereal or porridge, I would like toast. The heat of the food is variable.”

Access and flow

Surgical 6 ward was a surgical urology ward but had been designated a medical outlier ward. On the days of inspection 17 of the 20 beds were occupied by medical patients. There was a locum medical senior house officer (SHO) based on the ward. He told us the ward was included in the medical ward rounds and the system worked well. However, he noted the student nurses posted to the ward did not get enough surgical experience. He said the nurses were competent and capable to provide care to the medical patients. We were told earlier in the year there were around 40 medical outliers at the hospital, although during the inspection there were 21.

After our previous inspection we reported junior doctors and senior nurses spent a lot of their time taking bloods due to inexperienced nurses who did not have the competencies to take bloods and few phlebotomists. We spoke with a phlebotomist on medical ward 6 who told us she covered five wards taking bloods. She said the doctors helped with patients that were difficult to bleed for various reasons. Staff often identified patients to her requiring bloods to be taken early for discharge purposes. The acute medical units had band four technicians trained to take bloods. Night staff took bloods as much as they were able.

A more pressing issue which impacted on the unit as a whole was the failure of the decontamination machines. We were told that while the current arrangements of transporting ‘scopes to the KCH site and using the working decontamination machine/s at the hospital meant patient safety was not compromised, patient appointments were being cancelled at short notice. We were told in the month before our inspection 30-40 patients were cancelled, often on the morning of the planned procedure. The ward manager told us such appointments were rescheduled as soon as possible; sometimes the same week or at least within two weeks.

We spoke with staff on the various medical wards and units and the issue of discharge delays was mentioned on a number of occasions. Staff said the reasons for the patients having to wait for discharge from the hospital was often waiting for pharmacy to supply the patients medication to take home, delays with external placements involving social services and hospital transport arrangements. Whilst any delay was obviously frustrating for patients, relatives and hospital staff the reality of the situation was not as frequent as might be imagined. The medical department discharges a little under 1000 patients per month with a total at the year to 31 May 2017 of 11327. The number of recorded delayed discharges for the same 12 month period was 177, which equates to 1.56%.
Referral to treatment (percentage within 18 weeks) - admitted performance

The trust performed in line with or just below the national average. Referral to treatment percentages did not fall below the 80% mark and often match the 90+% national average, particularly between November 2016 and March 2017.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>97.9%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>87.50%</td>
<td>98.10%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>73.70%</td>
<td>93.80%</td>
</tr>
<tr>
<td>Neurology</td>
<td>67.10%</td>
<td>92.20%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

Between June 2016 and June 2017 there were 313 complaints about services at the Princess Royal University Hospital. The trust took an average of 35 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 25 days.

Several of the complaints had no resolution date added, it is unknown at this time if this indicated they were incomplete or there was a deficiency in the data supplied. The data supplied does not allow for breakdown by core service.

The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.

The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings, and we saw evidence of this in the minutes of meetings.
Between June 2016 and July 2017, the inpatient medical services at the PRUH received 72 complaints. A number appear to have been resolved within the 25 days stated in the hospital policy but possible incorrect data entry means we are unable to confirm it.

A number of the complaints had communication at the root of the problem. In conversation with the Patient Advice and Liaison Team (PALS) at the hospital they said the majority of the relatives and friends of patients who spoke to them felt the communication they had with staff on the wards or units was the reason for their visit. In a lot of cases PALS staff said were able to resolve the issue simply by having the aggrieved person speak to a member of staff with knowledge of their relatives’ situation.

**Is the service well-led?**

**Leadership**

There had been changes to the leadership structures of both the hospital and department since the last inspection. In January 2017 the trust was re-organised into three divisions – Urgent Care, Planned Care and Allied Critical Services; Networked Care and Princess Royal Hospital and South Sites. At the time of the last inspection executive leadership had covered both hospital sites and senior staff had reported this had made it difficult to engage with them. They told us at this inspection having a dedicated senior site manager and site director of nursing was working much better and they were visible and approachable.

Staff told us the leadership team were present on the wards. The heads of nursing, matrons and ward managers were visible throughout services and staff said they felt comfortable approaching them if they had any issues they wished to raise.

**Vision and Strategy**

The trust’s website on the king’s story page under the slogan King’s Values states; “Our vision is to become a fundamentally new kind of hospital built around patient need, offering all our patients – local, national and international – the highest quality of care, and to deliver this as part of a joined-up and well-managed healthcare system, built in partnership with GPs and other healthcare providers.” A similar statement was found on the PRUH website with the slogan “One Trust, many sites”.

The trust’s annual staff survey completed in December 2016, reported that out of the 36% (3,811) of the trust’s permanent staff who responded to the survey 60% (2,287) were definitely or to some extent aware of the trust vision and five year strategy “to give patients the best care globally, through innovation and continuous improvement”.

**Culture**

Staff we spoke with were universally proud of the contribution they made to the hospital individually and as part of the team. The ‘us and them’ sentiments expressed regarding the Denmark Hill site during our last visit had gone, although some staff were still not happy about travelling to Denmark Hill for some training elements.

When speaking to staff on the wards it was clear there was a collective mind set to get the job done and to do it well. We spoke with ward managers and matrons who regularly ‘rolled up their sleeves’ and worked a shift as a member of the nursing staff to cover staffing shortfalls.

Staff we spoke with told us they liked working at the PRUH. During the follow up inspection in October 2016 the majority of staff we spoke with told us they felt like a satellite to Kings Denmark
Hill and having to travel there for training rather than having it on site only reinforced that view. On this inspection there was a noticeable change in feedback with staff telling us they felt motivated and happy at King’s. Despite some training still taking place at the Denmark Hill site the general feeling was much more inclusive rather than ‘us and them’.

**Governance**

There were established governance mechanisms within the medical service to monitor and improve standards of patient care. We reviewed post-acute medicine clinical governance meeting minutes and saw a wide range of topics were discussed including incidents, complaints, area updates such as cardiology, GP alerts and the patient experience. We noted that various items were actioned after discussion and named individuals were tasked with the action and to report back at the next meeting.

It was clear the service had taken steps to address the issues raised after our last inspection. The completion of patient records including care plans and DNACPR forms had dramatically improved in the random records we examined. The security of medicines and resuscitation equipment had similarly improved. However, overall staff shortages, both the nursing and medical, remained an issue which we would have expected to see on the medical risk register, although it may be on the hospital or trust risk register.

**Management of risk, issues and performance**

The recruitment of nursing and medical staff remains an issue at the hospital with almost every medical ward and unit reporting vacancies, some as high as 50%. The ward managers we spoke with told us the trust was actively recruiting both within the UK and overseas. However, on many of the wards and units senior grade staff were filling in on shifts which took them away from their designated roles. In addition staff were agreeing to attend training on their rest days so as not to take themselves off the rota. One ward was constantly running over budget as the safe staffing levels for that ward were above the budgeted staffing levels. We were told a business case had been submitted two months ago but no decision had been communicated back to the ward manager at the time of our inspection.

**Engagement**

The hospital continued to engage with external stakeholders such as Healthwatch, NHS England, and the Bromley Clinical Commissioning Group all of which have contributed to the trust’s quality report for 2016/17.

The trust used data from staff leaver surveys, staff friends and family test (FFT) and the annual staff survey to inform them about how staff felt about working at the hospital. In the latest FFT survey 94% of inpatient patients would recommend the PRUH.

The trust held an annual public meeting where the trust’s five year strategy and other presentations were given.

Patient led assessments of the care environment (PLACE), where patients make up at least half of the team. Trust Governors and representatives from external stakeholders were also involved in 2016’s assessment at the PRUH.

The hospital provided the opportunity for the general public and patients to provide feedback online via the website.

**Learning, continuous improvement and innovation**

Recently introduced - an automated electronic alert system for patients with high national early
warning scores (NEWS) sent directly to the iMobile nursing practitioners Wi-Fi smartphone. Work was in progress to extend this so that iMobile staff received alerts of patient at high risk of sepsis.

Elderly Care: King's Dignity Awards September 2016 – A physiotherapy assistant at PRUH won the ‘Above & Beyond’ award for setting up Tea Club for Dementia patients.

SafetyNet is a trust wide initiative to share information and learning from incidents. The newsletters contain short summaries of the incidents with the main learning points.

**Surgery**

**Facts and data about this service**

Princess Royal University Hospital (PRUH) provided care and treatment for patients undergoing general and specialist surgery. This includes urology, trauma and orthopaedics, geriatrics, gynaecology, colorectal, bariatrics, ophthalmology and endoscopy services.

There are 140 beds located across eight wards, including two day patient wards, 12 operating theatres, a surgical admission unit, patient investigation unit and the day surgery unit. In addition there is a pre-admission service.

We visited six surgery wards and four operating theatres, the surgical admission unit, pre-assessment unit and the day surgery unit located in a separate building of the hospital site.

During our inspection, we spoke with 45 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the directorate leadership team, 14 patients and one carer. We reviewed 16 patient records and six bedside patient notes, some prescription charts and various equipment items on the wards.

A breakdown of wards and descriptions attached to the end of this report as Annex A.

**Is the service safe?**

**Never events**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should had been implemented by all healthcare providers.

Information provided by the trust confirmed two never events had occurred within surgery at the PRUH from 25 November 2016 and 31 August 2017.

The service had carried out investigations of the two never events and such matter were referred to the serious incident committee for a review. The first never event was dealt with in accordance with the duty of candour regulation and occurred in the operating theatre, the patient had been informed of what had happened after the surgery had been concluded and staff explained no harm had occurred to the patient. Staff we spoke to were aware of the incident and involved in the investigation. All staff were encouraged to speak up about concerns in future, to prevent a similar event.

Another never event related to a patient who had a drug incorrectly administered intravenously. Staff had followed procedures and a doctor, pharmacist and matron were all informed. The patient
and family were told what had occurred and no harm resulted. Staff apologised to the patient for what had happened and the event was recorded and an investigation commenced.

Staff told us lessons learned from the event were shared with other staff and recorded on the electronic database. We saw evidence of communication related to the learning from this event.

Between June 2016 and June 2017, the trust reported four incidents which were classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between June 2016 and May 2017.

Of these, the most common type of incident reported was
- Treatment delay meeting SI criteria with 10 (33% of total incidents).
- Slips/trips/falls meeting SI criteria with 8 (27% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with five (17% of total incidents).
- All other categories with three (10% of total incidents).
- Pressure ulcer meeting SI criteria with two (7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (7% of total incidents).
Incidents

Staff told us they were encouraged to report incidents and this culture of reporting incidents had continued from the previous inspection. Staff were able to identify different types of situations that should trigger incident reporting. A nurse on surgical ward 6 explained the steps of recording an incident; she described the event, actions taken and how to prevent the incident from happening again.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff still used an electronic computer incident reporting system, which could be accessed on computer terminals within surgical areas of the service. Staff were able to show us how to report incidents and were able to see how investigations were progressing. We were shown by staff how they could access the online system and they provided examples of incidents they had recorded.

Staff told us that monthly meetings took place to discuss incidents which had been recorded. Incidents were discussed with actions and updates, as well as those which required urgent review. We reviewed an example of learning from reported incidents which related to a patient who had suffered a stroke. Action plans were noted in the meeting minutes for managers to discuss with staff, how they should write clear notes which would be used when evaluating information recorded in patient records. The minutes showed this action had been done and was closed as completed.

Staff had regular feedback and learning from incidents which was then relayed to all staff, including incidents that occurred in other units within the trust. Learning was shared through emails, newsletters and staff meetings. For example we saw a ‘Safe Anaesthetic and Learning from Incidents’ (SALI) newsletter, which was produced monthly and provided staff with information and feedback from incidents which had occurred during surgery. We were told this newsletter had been issued to all surgery staff and staff we spoke to were aware of the newsletter and were able to tell us about the contents of the newsletter.

The service reported 21 serious incident investigations based on harm. Four incidents reported related to deaths, 13 where a major injury had occurred, two for moderate harm, one for minor harm and two where no harm occurred.

The service recorded 748 incidents on the electronic recording system for surgery between January 2017 and June 2017. From the information provided, incidents were investigated within the governance and risk management processes. Outcomes of the investigations were shared with family members and arrangements had been made for further discussions and explain actions taken.

**PRUH Surgery Als Jan 2017 - June 2017**

<table>
<thead>
<tr>
<th>Month</th>
<th>Surgery Adverse Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>128</td>
</tr>
<tr>
<td>Feb</td>
<td>111</td>
</tr>
<tr>
<td>Mar</td>
<td>127</td>
</tr>
<tr>
<td>Apr</td>
<td>113</td>
</tr>
</tbody>
</table>
Morbidity and Mortality meetings were held every month and incidents were reviewed by the Mortality Monitoring Committee. We saw information where two mortalities had been reported and reviewed. The information included the details of the surgery which had taken place, any complications which had occurred and actions taken. We reviewed information which indicated Morbidity and Mortality statistics had been reviewed every month. The statistics included information such as type of operations, complications and cancellations recorded. In the month of August 2017 a total of 74 operations were conducted and one death had been recorded. There had been two complications and two operations cancelled. Learning points from the death were recorded and shared with staff.

Duty of candour was understood by most nursing staff we spoke to on one ward we observed and listened to staff who followed the process and kept the patient and family members informed.

We reviewed information for two surgery incidents where duty of candour was applied and in both incidents the patient had been explained of the outcomes of the investigations and apologies made by staff.

The service recorded five incidents between September 2016 and September 2017, where patients were required to stay overnight for recovery stays, before transfer to critical care and all patients had undergone general surgery. Two of the five patients were expected admission and three were unexpected admissions.

**Safety thermometer**

The Safety Thermometer was no longer used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. This had been replaced with a new electronic application, called ‘Perfect Ward’ used to record data. Staff told us the application enabled ward managers and matrons to monitor surgical performance and respond as required. We saw data included audit results for infection control, hand hygiene and incident data. Key performance indicators were updated daily.

The findings from the Perfect Ward data were shared during ward meetings and were emailed to staff. This had helped the staff identify areas of work which could be improved and allowed managers to raise concerns and implement changes where required.

Staff collected safety information and shared it with other staff members, patients and visitors. The service used information to improve the care provided to patients. We observed information displayed on boards, within the wards which patients and the public could view.

**Cleanliness, infection control and hygiene**

The surgery wards and theatres we visited were all visibly clean and tidy. We observed the designated staff cleaning throughout the surgery unit. Staff we spoke with were familiar with the cleaning requirements for the area they worked in.

We saw information on handwashing which had improved since the previous inspection. The trust Infection Prevention and Control (IPC) team had written a report in June 2016 for an audit of isolation and handwashing facilities at the PRUH. The report found the majority of the wards did not have hand wash basins at the entrance to the surgical wards, in multi bed bays and within
multi bed bays with an en-suite. This had had subsequently been addressed, bringing the results up to 100% compliance. This was achieved by having supplementary sinks in corridors, all side rooms and hand basin in the sluice room. We observed hand-wash basins now in place at the entrance to surgical wards, the hand-wash basins were permanently fixed to the wall in multi bed bay areas.

All wards we visited had laminated posters to remind staff of actions to take to maintain and improve hygiene and cleanliness on the ward. We observed clear signs reminding staff to wash hands at ward entrances. We observed staff using hand gels and washing hands where required, when they entered and left surgical wards and in between patient care activities.

We reviewed hand hygiene audits for the service over a 12 month period, which showed a total of 91 audits had been conducted and covered every surgical ward. 56 audits completed were over the 90% target rate, 25 audits were between 80% and 90% and 10 audits were between 70% and 80%.

A surgical ward we visited had two patients in isolation rooms. We observed staff using the correct isolation precaution and staff followed hygiene and hand washing procedures before they entered and after they left the room. The appropriate gloves and aprons were outside the rooms for staff to use. We observed staff wearing the appropriate gloves and aprons when they were required.

We visited another surgical ward and observed a patient with an infectious disease, isolated in a room. A sign on the ward indicated the room should be cleaned five times a day. A cleaning schedule indicated that for the last four days the room had three daily cleans. We spoke to the ward nurse who advised the infection control team were aware and that the domestic team were unable to clean the room five times a day. We spoke to the ward matron, who confirmed after checking the infection control policy, the correct amount of cleans for the room was three times a day and she had relayed this information to all ward nurses and cleaning teams.

There was access to infection prevention and control link staff and members of the designated IPC team at the PRUH. They provided training, guidance and support related to clinical practice and patient care.

We observed staff complying with IPC policies, such as ‘bare below the elbows’ to allow thorough hand washing to be done.

We saw surgical staff working in theatres following the National Institute for Health and care Excellence (NICE) guidelines CG74. We observed staff washing their hands prior to preparing equipment for surgery, staff had removed all jewellery, artificial nails and nail polish before they started work. We saw staff preparing for surgery by using sterile gowns, gloves and antiseptic skin preparation.

Staff had a sepsis pathway to follow where patient’s needs required and needed it. Staff were able to describe how to care for patients in the event of infection.

The trust had a pathway to manage the screening for Candida auris. The trust also followed IPC guidelines for Candida Auris infection, which is an emerging infection and is resistance to many antifungals. Control requires strict isolation, contact screening and adherence to infection control measures. The service had one case of suspected Candida Auris and we were told by staff how they followed procedures to deal with the incident in line with IPC guidelines.

Nursing staff were responsible for cleaning equipment used by patients. We observed equipment which had been cleaned, such as commodes were labelled with ‘I am clean’ on them, with a date
indicating when the items had been cleaned. We also observed bed linen was handled in accordance with IPC policies.

We observed waste disposal bins being used for clinical and general waste. Waste bins were clearly labelled and we observed staff used the correct bins for clinical and general waste. We also observed sharps boxes were securely kept and not full, in all surgical wards and theatres. In addition all sharp boxes we checked were dated and signed appropriately.

Staff were able to show us on the trust intranet, how to access infection prevention control policies and procedures. The documents we reviewed were up to date.

We observed dedicated staff responsible for cleaning of ward areas and supplied with nationally recognised colour-coded cleaning equipment, which allowed them to follow best practice and minimise any possible cross-contamination

**Environment and equipment**

There were six operating theatres at the PRUH, one of which was closed at the time of our inspection for planned maintenance. Theatres were arranged safely with separate anaesthetic rooms going directly into the operating area but with closable doors. There was safe flow from clean to dirty areas. We observed separate scrub facilities and clean preparation areas for setting up instrumentation. There was secure access to theatres.

Ward areas were generally accessible to patients and staff and patient beds had enough space to be moved along corridors. There were shower and toilet facilities and when used these ensured patients had privacy. Curtains were used around beds in bay areas which ensured patients had privacy. There were also limited numbers of side rooms on each ward for patients who required isolation or private care treatments.

The day surgery unit had 30 beds and six operating theatres and five anaesthetic rooms. There was a large waiting room with ample seating for patients. The environment was suitable and was fit for purpose. The corridors were large and spacious and all areas were visibly clean and tidy.

There was a six bay recovery area and discharge lounge.

We checked a resuscitation trolley on surgical ward 6. The trolley was obstructed by a cooling fan and the cooling fan had been moved behind the reception desk area when mentioned to a ward nurse. The audit folder for the trolley confirmed the equipment had been checked on a daily basis and signed off by a member of staff. Upon inspection of the trolley, we found two blue sensor electrocardiograms (ECG) electrode pads had expired, dated 20 July 2017. The sharps box was empty and not dated or signed to indicate when it was put into use. We informed the ward nurse who removed the items and told us she would inform other staff members at the next team meeting, to ensure all items were checked on the trolley.

We found an ECG machine in the corridor which had no certified label to indicate if and when it had been checked. The label should be signed and dated. We informed the ward sister who confirmed she would arrange for the equipment to be collected and checked before it would be used again.

All equipment conformed to the relevant safety standards and was regularly serviced. For example, we observed staff following AAGBI Guidelines when they checked anaesthetic equipment. Staff performed a pre-use check to ensure anaesthetic equipment functioned correctly before used.

We observed theatre staff followed the WHO surgical safety checklist and five steps to safer surgery and monitored this to make sure they continued to follow the checklist accurately. The
WHO Surgical Safety Checklist was a core set of safety checks, identified for improving performance at safety critical time points within the patient’s care pathway and was used in any operating theatre environment.

Surgical operating theatres were found to be clean and there were separate clean preparation areas for used instruments, when they were removed from the operating room after being used. This equipment would then be ready for collection for re-processing by the decontamination service. Theatre equipment was cleaned by staff and we saw instruments were clean and ready to be used for operations.

Surgical instruments laparotomy sets used in theatres were reported to be more than 17 years old. The equipment had been maintained in the correct manner but staff told us the sets often had damaged or broken items. Staff made up sets by opening small sets or buying from small item budget. However the equipment used was fit for purpose.

We reviewed equipment audits for all surgical wards, operating theatres and the day surgery unit and records showed all equipment had been regularly checked and maintenance worked carried out when required. Information had also been recorded to show when an item had been installed and the last service date. Equipment audits also indicated when an item had last been repaired.

At the time of the last inspection endoscopy decontamination was on the hospital’s risk register and Joint Advisory Group (JAG) accreditation had not been achieved. JAG accreditation demonstrates that the endoscopy service has met nationally-recognised endoscopy standards. At the time of this inspection JAG accreditation had not been applied for due to the level of patient backlog and the status of the decontamination facilities. Endoscopy remained on the risk register.

Staff maintained decontamination standards in line with national best practice such as guidance from the Medicines and Healthcare Products Regulatory Agency.

We were told the plans to build a decontamination unit in the basement had not started yet. The 2016/2017 Director of Infection Prevention and Control Annual Report states, “Although ‘scopes are still processed clinically on the Princess Royal site, work is in an advanced stage to centralise all processing in a compliant on-site facility to commence operation late in 2017 or early 2018.”

The current endoscopy unit had three decontamination machines; although we were told only two were normally working at any time. As a result some ‘scopes were sent to the Denmark Hill site for decontamination. On the day of inspection only one machine was working as a second had failed the day before. We were told endoscopy was going to be under the surgical governance structure from October 2017. We noted endoscopy was not on the hospital’s medical risk register at the time of this inspection, although it was on the surgical risk register.

**Medicines**

There were systems to ensure the safe supply and administration of medicines in accordance with NICE guidelines for the safe and effective use of medicines.

Medicines management within the theatre areas had improved since our last inspection, medicines were stored securely in locked cupboards and records were kept updated for checks conducted on medicines that were accessed by staff.

We observed staff on surgical wards preparing and administering intravenous and oral medicines. They followed correct procedures, including checking the dosage, expiry dates, patient identification and allergy information. We observed nurses referred to care plans to ensure patients received the correct medication. A check list was completed by staff to reflect the medication had been taken by the patient.
Medicines management on all surgical wards was good and nursing staff were aware of the policies on the administration of Controlled Drugs (CDs). CDs were stored in lockable, wall-mounted cabinet within a cupboard. On each unit, the keys for the cupboards were held by an allocated nurse, in line with trust policy.

All surgical wards had pharmacist support who were involved in monitoring and maintaining medicines stock. We reviewed records which confirmed pharmacists reviewed prescriptions charts to identify any issues. We checked pharmacy ordering books, which showed they had been completed correctly with no gaps in the recorded information.

We checked the expiry dates of a number of medications across surgical wards. We found one expired medicine on surgical ward six, which had expired at the end of August 2017 and was still in the medicine cupboard. The product contained two glucose liquid bags, one of the bags were missing and the other had expired. We mentioned it to the matron on duty, who removed the medicine and told us she would make arrangements for the pharmacy to replace it.

We observed that medicines were stored in dedicated medicine fridges when required, these were locked securely and the fridge temperature had been recorded. Checks of temperatures were recorded daily and also included the room temperature. This ensured medicine were stored in the correct conditions, as required by national safety standards.

Records
Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

The service used paper documentation for recording patient information. Staff told us the service planned to introduce a new electronic patient record (EPR) system; this was scheduled to be implemented in October 2017. It would align the service with the other parts of the trust that currently use the EPR system.

We reviewed 16 patient records and found that all records had been completed to a good standard. All records had relevant completed assessments and were signed off by staff. We reviewed six nursing plans which all showed up to date risk assessments had been conducted and ongoing monitoring through ward rounds, was being recorded. All patient records were kept secure in a locked filing cabinet.

We found there was multidisciplinary input where required, which included entries made by allied health professionals, including physiotherapists and occupational therapists, and dietitians. We saw evidence of falls, pressure ulcer and nutritional risk assessments with appropriate care plans in patient record reviewed.

Whilst reviewing the patient records, we observed patients notes recorded on the EPR system at Denmark Hill site, which were printed off onto paper and included in the patients’ medical record. Staff told us this improved the patient flow from the last time we had inspected the service.

We reviewed a patient record from the surgical admissions unit which at the pre admission stage, did not include an allergy assessment. However previous notes in the record identified the patient was allergic to certain medicines. We mentioned this to staff who were aware and told us an assessment would be carried out and included in the patient record.

Safeguarding
Staff told us they were able to identify abuse and described how to report such incidents. Staff were able to provide examples of when they had reported such incidents. Information on reporting adult and children’s safeguarding concerns was displayed on all wards we visited.
There was a safeguarding team which staff could make reports to when required and safeguarding incidents were reviewed by this team with feedback shared with staff. Eight safeguarding incidents had been recorded by the service in the last 12 months.

Staff told us they also received feedback from managers discussed safeguarding themes with their teams every month. We saw an example of this when we observed a team huddle and during a team handover.

(Source: Routine Provider Information Request (RPIR))

**Safeguarding training completion rates - PRUH**

The trust set a target of 80% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:
Medical staff were underperforming against the trusts 80% target. Nursing staff were exceeding the target at 90%. It was not explained why there was a 0% rate for Safeguarding Adults level 1. The reason provided for this missing data when we asked during the inspection, was due to the records being transferred to the new training database system so were unavailable.

**Mandatory Training - PRUH**

The trust set a target of 80% for completion of mandatory training. A breakdown of compliance for mandatory courses between June 2016 and May 2017 for medical/dental and nursing staff in PRUH is shown below:
Medical staff were performing below the trust target of 80% completion of mandatory training, with a completion rate of 50%. Nursing staff were performing above target with a completion rate of 84%.

The service had implemented a new electronic system to manage all training and development of staff. We observed how the new system was being used by managers to monitor staff progress with training courses and identify training gaps for all staff. Training delivered through an e-learning service as well as face-to-face.

We were shown by a nurse team leader how staff training records could be tracked to ensure all mandatory training had been completed. All staff for the team had completed the required training except for two nurses, one had been on long term sick and the other was on maternity leave.
We saw information from surgical sisters meeting minutes that leadership training had been offered to all band seven sisters and they had been welcomed to apply for this additional training to enhance their development. We saw evidence that all staff are sent emails to encourage them to attend training courses to improve their skill sets.

Nurses mandatory training also included Basic Life Support (BLS) and Paediatric Immediate Life Support (PILS) and understood their roles regarding emergency resuscitation protocols.

**Assessing and responding to patient risk**

Staff were able to identify and escalate risks which affected patients on surgical wards. Patients’ were risk assessed before being admitted to surgical wards and this information was recorded in the patient records.

We were told by staff that the National Early Warning Scores (NEWS) calculation had been used to refer patients to iMobile (the critical care outreach team). Staff told us that the iMobile team supported ward staff to provide care to deteriorating patients. Staff told us matrons and team leaders on wards were available and provided advice and assistance in situations where patients were required to be escalated.

We observed staff at handover meetings that discussed risks to patients and advised colleagues about patients that required to be monitored. The service had a risk register in place which was used to highlight risks and actions that needed to be taken.

Staff used the ‘five steps to safer surgery’ in operating theatres and included the WHO Surgical Safety Checklist which was used to ensure patient safety during surgery. Information supplied showed the service had an overall completion rate of 89% for audits and compliance with the safety checklist.

**PRUH Sites VTE audit information September 2016 - August 2017**

% VTE risk assessment on admission*

<table>
<thead>
<tr>
<th>Surgical Ward</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>SW3P</td>
<td>93</td>
<td>95</td>
<td>96</td>
<td>95</td>
<td>99</td>
<td>93</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>SW4P</td>
<td>95</td>
<td>95</td>
<td>97</td>
<td>96</td>
<td>98</td>
<td>98</td>
<td>97</td>
<td>100</td>
<td>86</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>SW5P</td>
<td>93</td>
<td>93</td>
<td>93</td>
<td>92</td>
<td>88</td>
<td>91</td>
<td>95</td>
<td>97</td>
<td>88</td>
<td>88</td>
<td>93</td>
</tr>
<tr>
<td>SW6P</td>
<td>92</td>
<td>90</td>
<td>90</td>
<td>91</td>
<td>98</td>
<td>98</td>
<td>95</td>
<td>97</td>
<td>95</td>
<td>100</td>
<td>90</td>
</tr>
<tr>
<td>SW7P</td>
<td>93</td>
<td>92</td>
<td>100</td>
<td>93</td>
<td>97</td>
<td>94</td>
<td>85</td>
<td>92</td>
<td>96</td>
<td>87</td>
<td>89</td>
</tr>
<tr>
<td>SW8P</td>
<td>95</td>
<td>92</td>
<td>92</td>
<td>95</td>
<td>93</td>
<td>94</td>
<td>96</td>
<td>96</td>
<td>99</td>
<td>97</td>
<td>94</td>
</tr>
<tr>
<td>Day surgery Unit</td>
<td>98</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>98</td>
<td>99</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Cumulative % risk assessment score based on total number of admissions**

<table>
<thead>
<tr>
<th></th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96</td>
<td>97</td>
<td>97</td>
<td>98</td>
<td>99</td>
<td>97</td>
<td>98</td>
<td>97</td>
<td>96</td>
<td>97</td>
<td>95</td>
</tr>
</tbody>
</table>
We noted venous thromboembolism (VTE) assessments conducted by the service exceeded the cumulative total targets of 95% for the last 12 months. The day surgery unit and the admissions lounge exceeded the target for every month.

**Nursing staffing**

Kings College NHS Trust reported their staffing numbers below for the period June 2016 and May 2017. These numbers fall below the trusts target for a WTE staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
</tr>
</tbody>
</table>

**Vacancy rates - PRUH**

Between June 2016 and May 2017, the trust reported a vacancy rate of 14% at the PRUH for qualified nursing and midwifery staff. This was higher than the trusts target vacancy rate of 8%. There was some variation in the rate over a 12 month period, peaking at 16% in March/April 2017 and dipping to 11% in November/December 2016.

**Turnover rates - PRUH**

Between June 2016 and May 2017, the trust reported an annual turnover rate of 15.3% with an average monthly turnover rate of 1.2% at the PRUH for qualified nursing and midwifery staff; this was lower than the trusts target annual turnover rate of 20%.

**Sickness rates - PRUH**

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 3.3% at PRUH for qualified nursing and midwifery staff. This was higher than the trust’s target sickness rate of 3%.

**Bank and locum staff usage**

The data supplied was incomplete and included inconsistencies. Due to this analysis had not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.

Information provided showed in September 2017 the service used a total of 1045 bank and agency staff. Bank and agency staff had been used on six surgical wards and the planned investigation unit overflow at the PRUH.

**Medical staffing**

The trust had reported their staffing numbers below for the period June 2016 to May 2017. The below the trust’s target for a WTE staffing level of 2183.09 within the medical staff arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>1885.88</td>
<td>2090</td>
</tr>
</tbody>
</table>
Vacancy rates - PRUH

Between June 2016 and May 2017, the trust reported a vacancy rate of 20% in medical and dental staff at PRUH. This exceeded the trust’s target vacancy rate of 8%.

Turnover rates - PRUH

Between June 2016 and May 2017, the trust reported an annual turnover rate of 40% and a monthly average rate of 3.4% in medical and dental staff at PRUH. This exceeded the trust’s target turnover rate of 20%. There was a significant spike in turnover in August 2016, where the rate was recorded at 19.8% for the month. This may indicate redundancies or the movement of a particular team to a new area. This in turn may be a possible cause for the high turnover rate.

Sickness rates - PRUH

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 2.5% at PRUH for medical and dental staff. This was lower than the trust’s target sickness rate of 3%.

Bank and locum staff usage

The data supplied was incomplete and included inconsistencies. Due to this analysis had not been conducted on this data pending clarification. Amended data was not available at the time of production of this report.

Staffing skill mix

Between 01 May 2017 and 31 May 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>41%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior</td>
<td>6%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Major incident awareness and training
Staff we spoke to told us they were aware of the trust major incident plan and were able to show us how to access the plan on the trust intranet. Staff told us the plan was intended to provide direction to all departments during a major incident or mass causality incident. In the event of an emergency there were clear procedures in place for staff to respond to challenging situations.

**Major incident training completion rates**

No training data pertaining to major incident awareness or training was available at the time of production of this report.

**Is the service effective?**

**Evidence-based care and treatment**

Clinical guidelines were in place to inform patient care and treatment for specific procedures and interventions. We saw evidence that clinical guidelines were written in line with current best practice and referenced national standards.

Policies and procedures were available on the trusts intranet page and staffs were able to show us how to access them. Staff also had hard copies in case of IT problems and some staff told us they found it easier to refer to hard copies.

We saw examples of care pathways completed for patients who had specific conditions. These pathways followed evidence based guidance for management and treatment of conditions.

We reviewed 16 patient records and six bedside patient notes and confirmed patients care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) and Royal College guidelines. This included following guidance regarding medicines and anaesthetic risk scores for patients who had attended pre-admission assessments. In surgical theatres we also observed staff following NICE CG74 guidelines to reduce the risk of surgical site infections.

**Pain relief**

Pre-operative assessments included in patient records we reviewed, included information for existing pain management for the patient and medication they had taken. Pain relief to be provided to patients was also noted.

Patient's we spoke to also confirmed staff had consulted them about their pain and the appropriate medication had been administered accordingly. We observed pain score assessments were conducted and completed to a good standard; staff also followed up on how the patient responded to pain relief and monitored this by further re-assessments.

Staff confirmed they had good access to the hospital pain team when required and referrals could be made by nurses and medical staff. Staff told us they had referred patients with severe pain to the pain team and they would offer support to nursing staff. Nurses also told us patient’s pain relief was managed when they returned from surgery theatres.

We were told by staff that pain relief audit meetings were held every month to discuss how the needs of patients were met and to discuss the management of pain relief. We were also told how learning from these meetings was shared with all other staff.

**Nutrition and hydration**

Staff used a malnutrition universal screening tool (MUST) to identify patients who were at risk of malnutrition. There were five steps for this risk assessment and involved weighing the patient regularly to monitor any weight changes and allocate a score based on the risk.
We reviewed information for MUST audits conducted and these showed inconsistent results with the completion of assessments over five wards. One ward had completed all three assessments and was up to date. A second ward had completed two assessments and a third was incomplete. Three wards had completed at least one assessment but other assessments conducted had information missing or had not been done.

The nutritional needs of patients were evaluated by nursing staff as part of an initial assessment and also if their needs changed. We observed staff in the Patient Investigation Unit who helped patients when required with eating and drinking during the evening meal. We saw protected meal times in place and these were respected by staff and visitors. This meant all non-urgent duties on the ward were stopped and staff assisted patients with meals as required.

We observed that fluid balance charts were used where patients had their intake and output measured when patients required intravenous fluids.

Nurses told us they had access to dietitians who visited the wards to monitor patients and we saw dietitian’s notes in medical records we reviewed.

**Patient outcomes**

We reviewed three referral to treatment reports which had breached the 52 week timescale for completion. All three cases had been reviewed and audits were created to log all steps taken and why the breaches had occurred. Details recorded showed the actions taken and how the breach had affected the patient. In all three cases no physical or psychological harm had occurred to the patient and there was no significant change in treatment or change in the outcome had affected the patient.

<table>
<thead>
<tr>
<th>MONTH</th>
<th>SUITE_TYPE DAY</th>
<th>SURGERY CENTRE</th>
<th>MAIN THEATRES</th>
</tr>
</thead>
<tbody>
<tr>
<td>201706</td>
<td>1044</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>201705</td>
<td>984</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>201704</td>
<td>707</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>201708</td>
<td>877</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>201707</td>
<td>1035</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4647</strong></td>
<td><strong>49</strong></td>
<td></td>
</tr>
</tbody>
</table>

There were a total of 49 patients who were discharged home from recovery from the PRUH.

There were a total of 271 emergency readmissions for surgical specialties only from September 2016 to September 2017. The readmission rate for this period was 0.97%.

**Princess Royal University Hospital**

Between 01 May 2016 and 30 April 2017,

All patients at Princess Royal University Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at Princess Royal University Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
Urology patients at Princess Royal University Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

ENT patients at Princess Royal University Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at Princess Royal University Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at Princess Royal University Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at Princess Royal University Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at Princess Royal University Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - Princess Royal University Hospital**

![Elective Admissions Chart]

**Non-Elective Admissions - Princess Royal University Hospital**

![Non-Elective Admissions Chart]

**Hip Fracture Audit - PRUH**

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.1% which was within expected limits and similar to the national aggregate. The 2015 figure was 11.6%.

The proportion of patients having surgery on the day of or day after admission was 83.7%, which slightly below the national standard of 85%. The 2015 figure was 70.5%.

The perioperative surgical assessment rate was 95.3%, which was lower the national standard of 100%. The 2015 figure was 81.7%.

The proportion of patients not developing pressure ulcers was 99.1%, which falls in the upper 25% of trusts. The 2015 figure was 97.3%.

The length of stay was 15.9 days, which falls in the upper 25% of trusts. The 2015 figure was 21.8 days.
Bowel Cancer Audit - PRUH

In the 2016 Bowel Cancer Audit, 50% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was lower than the national aggregate of 69%. The 2015 figure was not reported.

The risk-adjusted 90-day post-operative mortality rate was 2%, which was lower than the national aggregate of 3.8%. The 2015 figure was not reported.

The risk-adjusted 2-year post-operative mortality rate was 14.9%, which was lower than the national aggregate of 20.9%. The 2015 figure was not reported.

The risk-adjusted 30-day unplanned readmission rate was 16.4%, which was higher than the national aggregate of 10.1%. The 2014 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 48.2% which was lower than the national aggregate of 50%. The 2015 figure was not reported.

(Source: National Bowel Cancer Audit)

National Vascular Registry – Trust Wide

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% for Abdominal Aortic Aneurysms, indicating that the trust performed within expectations. The 2015 figure was 1.3%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 14 days, equal to the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 1.8%. The 2015 figure was 1.1%.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit – Trust Wide

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.5%. This placed the trust within the lowest 25% of all trusts for this measure.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.2%, significantly higher than the national aggregate.

This metric was defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit – PRUH

In the 2016 National Emergency Laparotomy Audit (NELA), the Princess Royal University Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 82 cases.
The Princess Royal University Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 56 cases.

The Princess Royal University Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 51 cases.

The Princess Royal University Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 33 cases.

The risk-adjusted 30-day mortality for the Princess Royal University Hospital was within expectations based on 219 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

• Groin Hernias
• Varicose Veins
• Hip Replacements
• Knee replacements

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was worse than the England average.

For Varicose Veins, performance was worse than the England average.

For hip replacements, performance was about the same as the England average.

For Knee replacements was about the same as the England average.

(Source: NHS Digital)
Competent staff

Staff employed in surgical areas had the required skills and competencies to provide surgical related activities.

Additional competence based training was made available to all nursing staff around the presentation and management of mental health patients through team study days, which occurred four times a year. Basic elements of this training had now been incorporated into the induction programme for all new nursing staff, along with a resource document which includes a risk assessment tool and useful contact names and numbers.

There was additional competency based training provided by the Adult Safeguarding Team for Deprivation of Liberty Safeguards. The training sessions provided are additional to the Mental Capacity Act 2005 and Safeguarding Adults training modules

Appraisal rates - PRUH

Between June 2016 and May 2017, 42% of staff at PRUH had received an appraisal compared to a trust target of 90%. 89 entries within the data set had been left blank for number of appraisals carried out. This could indicate incomplete data recording of this material. It was possible this had caused the low percentage score within the site. A split by staff group can be seen in the graph below:

(Source: Routine Provider Information Request (RPIR))

We were told staff felt supported and had the correct amount of supervision to do their job effectively. Staff told us they were further supported through appraisals, access to relevant training and from other team members. We saw evidence of staff being supported during our visit and we observed staff interaction during team handovers which reflected a good team working environment.

Staff told us they had yearly appraisals with managers and were able to discuss development and further training plans for the year and were then arranged accordingly. We were told by matrons that appraisals for staff on surgical wards were up to date. Matrons also told us staff were provided with an additional four study days throughout the year to be used for their personal
development. We reviewed information from staff that confirmed study days had been allocated to them to develop existing and new skills they had identified during their appraisals.

We observed audits which confirmed all new staff including bank and agency staff had completed an induction training programme. This had been implemented to ensure staff had the appropriate knowledge to perform the duties required for their roles.

Some staff had told us they had taken on additional responsibilities as champion nurses for areas such as infection control and provided updates to the ward after they attended team meetings.

The Junior Doctors felt they received enough support from their seniors when required and felt comfortable in escalating problems when they occurred. They thought the surgical wards provision of teaching and training was excellent.

**Multidisciplinary working**

We were told by staff that multidisciplinary working (MDT) monthly meetings had been held within the service and minutes were recorded.

Staff on surgical ward 6 reported that physiotherapist and occupational therapists attended the ward to be updated on each patient’s progress. Nursing staff reported therapists were well respected and worked really hard despite working under pressure. There was clear indication staff from different teams worked well together and there was a mutual respect and understanding for the importance of the role of each team and how working together resulted in good care for patients.

Patient records also showed input from allied health professionals including physiotherapy, dietitians, occupational therapists, pharmacists, nursing and medical teams were working well together and provided good standard of care to patients. We observed allied health professionals attended ward rounds with doctors and nurses.

Staff on the ward were aware of how to refer relevant patients to the therapy team. Staff could easily locate contact details for the therapists and had knowledge of what patients should be referred to them, referrals to the therapy team were seen promptly within 24 hours of making the referral.

Information provided indicated that medicine charts were screened within 24 hours of a patient’s admission and reconciled within 46 hours. We were told that the pharmacist regularly reviewed drug charts and following up doctor’s prescriptions. A medicines review had been undertaken with the ward manager every month. This was also reflected in the records we saw.

**Seven-day services**

The service provides care seven days a week and 365 days a year.

Occupational therapy and physiotherapy were available five days a week from Monday to Friday and limited physiotherapy service was available for four hours on a Saturday and Sunday morning.

Respiratory physiotherapy was available to patients across all specialties, as required.

Speech & language therapy and dietetics were available on all weekdays to patients across all specialties, as required.

Pharmacy services were available seven days a week. Pharmacists visited wards on Saturday morning and on call pharmacists were also available outside normal working hours.

The service had seven day out of hours computed tomography service, partly provide by medical outsourced provider and by the radiologists.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) access was available for theatres and diagnostics out of hours. NCEPOD was staffed out of hours by two scrub nurses, one anaesthetic practitioner, one theatre support worker and one recovery nurse.

Health promotion

Staff told us they were able to access information and guidance through the trust intranet and we observed staff using the intranet to access information related to shared learning within the trust, surgery related guidance and general information.

Information communicated to staff was done through monthly emails, newsletters, meetings and team huddles. We observed staff huddles during our visit to surgical ward and theatres at the start of shifts. During these meetings staff shared information on patient care during the night shift and relayed important information with any problems they had identified.

Theatre staff held a briefing prior to the start of theatre lists. This provided an opportunity to discuss the activity, any patient specific matters, staffing or equipment issues.

Staff on all surgical wards had told us that access to patient records had improved since the last inspection. For example, on surgical ward seven we were told that every patient that was admitted to the ward had completed patient records. For patients being transferred from outside the service a complete record was sent with the patient. We reviewed a record for a patient transferred from Denmark Hill and a full set of records had been included and sent to the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were aware their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff we spoke with were able to describe how they assessed mental capacity and their management of the patient and escalation pathways if needed. We saw completed consent forms in patient’s records we reviewed. Consent forms were completed correctly and all relevant information recorded on the form.

Information provided by the service stated that there was an adult safeguarding team which provided advice and support to staff across the site. The team provided assistance when required, to patient’s the safeguards had been applied to. This included assessment of mental capacity, best interest decision making, least restrictive care planning and an overall review of the protocol.

Is the service caring?

Compassionate care

Patients we spoke to were satisfied with the standard of care provided by staff and told us their privacy and dignity was respected. Patients felt staff involved them in decisions about their treatment and were informed how the care would be delivered during their stay.

We observed staff treating patients with respect and being professional and also keeping patients informed with regards to the care provided to them.

The Friends and Family Test response rate for Surgery at King's College Hospital NHS Foundation Trust was 36%, better than the England average of 29% between July 2016 and June 2017.
A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at King's College Hospital NHS Foundation Trust, by site:**

![Graph showing response rates](image)

**Friends and family test - PRUH**

<table>
<thead>
<tr>
<th>Total Resp</th>
<th>Avg Resp rate</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Ward 3</td>
<td>500</td>
<td>54%</td>
<td>98%</td>
<td>90%</td>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>99%</td>
<td>95%</td>
<td>90%</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical Ward 4</td>
<td>500</td>
<td>75%</td>
<td>97%</td>
<td>90%</td>
<td>96%</td>
<td>95%</td>
<td>91%</td>
<td>78%</td>
<td>0%</td>
<td>93%</td>
<td>99%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Surgical Ward 5</td>
<td>277</td>
<td>26%</td>
<td>94%</td>
<td>88%</td>
<td>95%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>98%</td>
<td>99%</td>
<td>95%</td>
<td>0%</td>
</tr>
<tr>
<td>Surgical Ward 6</td>
<td>250</td>
<td>29%</td>
<td>81%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>92%</td>
<td>93%</td>
<td>0%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

We observed staff introducing themselves by name and explaining their roles to patients. Patients also confirmed that this occurred.

We noted examples of conversations regarding how a patient’s care and treatment were managed in a compassionate way. There were quiet rooms available where staff were able to have sensitive conversations with them and relatives if required.

Surgical ward six had a room named after ex colleague who had passed away called Carol’s room; staff told us Carol had always mentioned the need for such a room for patients and family members. As a tribute to her, mangers within the service re-developed an old storage room which
had been converted into a quiet room or private area where patients or family members could talk in private with staff.

We spoke with 14 patients and one carer. All their experiences were positive. Patients described staff with the following quotes, ‘so grateful’ that they helped, ‘staff always treat me with respect, calling me by my name’ and ‘everything is good, bang on’. One patient said in relation to staff ‘they are brilliant here.’

We observed that staff asked patients how they were feeling and asked whether they needed anything in a polite and friendly manner.

We also observed staff leaving a cubicle and drawing the curtains to ensure the patient had privacy, this showed that staff were aware of the need to treat patients with respect.

During our visit to surgical ward seven we saw a number of thank you cards and gifts from patients to staff. We read three cards patients had written thanking individual staff members and teams for the kind care they were provided during their stay on the ward.

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

Staff involved patients and those close to them in decisions about their care and treatment. They made sure patients had information about their treatment, surgery and aftercare. For example, we observed a nurse in the day surgery unit giving reassurance and advice on how to deal with stomach cramps who had analgesia administered to her. The patient was grateful the nurse had helped her.

We observed positive interactions between doctors, nurses, therapists and patients. For example we observed a nurse on surgical ward six lower a patient’s bed, so that she could see her visitors and communicate with them with ease.

All patients we spoke with in the day surgery unit were very positive about information provided to them including after care. One patient said there was “no feeling of being rushed to go home”. Although leaflet had been provided about after care, staff went back to patients in every case and repeated the instructions, answered questions and assisted with the escort home.

**Emotional support**

Staff provided emotional support to patients and provided spiritual, pastoral and access to chaplaincy as required. We saw information leaflets about the chaplaincy service throughout the medical wards in the hospital.

We observed emotional support being provided to family members of a patient in the patient investigation unit. Staff provided the family with advice and feedback how the patient was feeling after surgery. The family were grateful for the care provided to the patient and we observed staff being thanked by the family for all they had done during the patients stay on the ward.

All the wards we visited, we saw evidence of patient’s family and friends who were happy with the care and support provided by staff, we looked at a number of thank you cards which thanked staff for the emotional support they provided to the patients during their stay.

We observed patients physical needs assessed by nurses who addressed nutrition, hydration, pain relief and personal hygiene. We were told by staff that counsellors were available to address psychological needs of patients who experienced any distress or anxiety during their stay on surgical wards.

Is the service responsive?
Is the service responsive?

Service delivery to meet the needs of local people

The care and treatment provided to patients at the service had been assessed by staff in order that the actions taken were responsive to meeting them.

The majority of surgical activities at the PRUH were day case procedures, which contributed 51% of activity between September 2016 and September 2017. Elective surgery made up 18% of the work, and emergencies contributed 30% to activity.

The service opened a new surgery admissions unit (SAU), in response to findings from the inspection April 2015. The SAU was a waiting area for patients before they attended planned surgery and was located next to the operating theatres. The unit had a reception desk, main waiting area, male and female patient waiting rooms and four consulting rooms. SAU was fit for purpose and had facilities to meet needs of local people. For example, each waiting room had private changing room, toilet, television, comfortable chairs and kept clean and tidy. The main waiting area had ample seating, oxygen cylinders for patients use, television and up to date magazines for patients and visitors.

Staff in the SAU told us patients were booked in for operations in theatres one month in advance and specialty leads had been responsible for reviewing the theatre lists.

The day surgery unit pre-assessed patients in accordance with NICE guidelines. If concerns were identified at this stage and if necessary the patient would be referred to the consultant anaesthetist, who reviewed the notes on a weekly basis. There was also a duty anaesthetist on site, who could be approached to review the patient. Patients could also be referred back to their GP if appropriate.

Mental health patients’ needs were met by the service by registered mental health nurses. A dedicated mental health handover document is used to ensure all risks that could affect a patient are identified. Patients were assessed by a dedicated psychiatric liaison team and assessments were followed up by other teams in ward areas. This service had been provided by South London and Maudsley (SLAM) specialist mental health trust.

The learning disability/adult safeguarding team worked with community learning disability services and checked if patients who had been admitted, had a hospital passport which would prompt the team looking after the patient to consider any reasonable adjustments and whether the person may need additional support, privacy in a side room and access to easy read information. If a patient had been known to the community learning disability team then a request would be made for any information or reports to be shared which would assist the team with the eating and drinking, communication and physio needs of the patients.

Average length of stay - Trust
Average length of stay - PRUH

Between April 2016 and March 2017:

The average length of stay for all medical elective patients at Princess Royal University Hospital was 2.1 days, which was lower compared to the England average of 3.2 days.

The average length of stay for General Surgery medical elective patients at Princess Royal University Hospital was 2.6 days, which was lower compared to the England average of 3.3 days.

The average length of stay for Urology medical elective patients at Princess Royal University Hospital was 1.7 days, which was lower compared to the England average of 2.0 days.

The average length of stay for ENT medical elective patients at Princess Royal University Hospital was 0.7 days, which was lower compared to the England average of 1.6 days.

The average length of stay for all medical non-elective patients at Princess Royal University Hospital was 5.8 days, which was higher compared to the England average of 5.1 days.

The average length of stay for General Surgery medical non-elective patients at Princess Royal University Hospital was 5.4 days, which was higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics medical non-elective patients at Princess Royal University Hospital was 7.3 days, which was lower compared to the England average of 9.0 days.

The average length of stay for Urology medical non-elective patients at Princess Royal University Hospital was 4.1 days, which was higher compared to the England average of 3.0 days.
Meeting people’s individual needs

The ward environments were suitably laid out to provide the required level of care to patients. There were reception desks on all wards, which were staffed by ward clerks. This meant visitors had a point of contact on admission to the ward Monday to Friday. Surgical wards we visited all had separate bed areas for men and women.

Water was available in all areas of the department and we observed staff offering it to patients.

The surgical wards had a hostess service offering food and drinks to patients. This included hot food. At night nursing staff offered patients hot drinks and a vending machine was available within the patient investigation unit. Patients told us that staff regularly offered them food and drink.

There was a variety of meals available, including special diets or preferred foods based on religious or choice.

We observed patients receiving evening meal whilst visiting the patient investigation unit. Nurses and health care assistants ensured patients had eaten their meals whilst and during ward rounds made entries on checklists to record what the patient had eaten.

The patients we spoke to had described the food they had been provided during meal times, was of a good standard and a good variety of food was available to all patients.

A patient we spoke to in the day surgery unit had explained staff were able to provide information, verbally and through leaflets which explained the treatment and care to be provided by the surgeon. Information was available on all wards which provided patients with information about the care they could expect and information about the ward. The information was available in different formats and languages, to meet the needs of the patients visiting the ward.

Translation services were provided by the service if required and staff were aware this could be arranged through the trust intranet services.
Information provided outlined details of how the service meets the needs of vulnerable people for example those living with dementia, learning difficulties or poor mental health. The service had a dementia and delirium (DAD) team which provided support for bedside treatment and care for patients aged 18 and over. The DAD team also support patients with other communication problems and involved in promoting delirium prevention. There were memory clinics which provided diagnostics, assessment and treatment planning to support patients with dementia and their carers. We observed dementia and delirium leaflets and posters on display which provided information and created awareness for the general public.

Patients' needs with learning disabilities were met by the learning disability and adult safeguarding team. This team would be notified of any patient with a learning disability being admitted and a review would be conducted to ensure the service would be able to meet the needs of the patient. Adults with special needs were informed in advance of the planned operation of the treatment to be provided and staff met with carers to plan the care to be provided to them. For example we were told that recently the service had a patient with Asperger’s syndrome, who met with staff in advance of surgery and by understanding the patient’s needs, were able to provide care without any problems.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between June 2016 and May 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery had underperformed against the England average for the entire reporting period. It reported 63% in June 2016 and then experienced a period of decline to 53% as of May 2017.

![Graph showing referral to treatment (percentage within 18 weeks) for June 2016 to May 2017.](Image)

*(Source: NHS England)*

**Referral to treatment (percentage within 18 weeks) – by specialty**

A breakdown of referral to treatment rates for Surgery broken down by specialty was below. Of these, one speciality (Oral Surgery) was above the England average and four of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>76%</td>
<td>67%</td>
</tr>
<tr>
<td>Urology</td>
<td>61%</td>
<td>78%</td>
</tr>
<tr>
<td>ENT</td>
<td>41%</td>
<td>66%</td>
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</table>
At the time of inspection the endoscopy unit had one recovery area which meant they had to have single gender lists. A second recovery area was planned to enable dual gender lists and greater patient throughput. The ward manager was unable to tell us when the new area might be available.

**Cancelled operations**

A last-minute cancellation was a cancellation for non-clinical reasons on the day the patient was due to arrive, after they had arrived in hospital or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The trust had notably underperformed in this area. From Q2 2015/16 onwards, the trust’s percentage of cancelled operations had risen above the national average. This had peaked in Q1 of 2016/17, where it reached approximately 21%. Despite some fluctuation throughout 2016/17, the trust’s performance had not returned to the national average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**
- King’s College Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Site Group</th>
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<table>
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<th>201703</th>
<th>201704</th>
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<td></td>
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<td>1</td>
<td></td>
<td></td>
<td>2</td>
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<tr>
<td>Trauma &amp; Orthopaedics</td>
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<td></td>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

There were a total of 8 cancelled operations that were not treated within a 28 day period at the PRUH which had improved from the last inspection.

(Source: Trust Provider Information Request)
Over the two years the percentage of cancelled operations at the trust showed a mixed performance. For quarters 1-4 2015/16, the trust performed above the England average. There was then a notable sharp decline in Q1 2016/17 to below the England average. The trust’s performance had stabilised for the rest of the reporting period, showing some minor improvement in Q3 2016/17, before declining again into Q4 2016/17.

(Source: NHS England)

PRUH had opened up a new surgical admission lounge in the last six months which was fit for purpose and well equipped.

Patients coming on for day surgery operations were seen in the pre-assessment unit at the Orpington site.

Patients received information before and after surgery and advice about medication verbally and in written format.

We found patients would attend for planned surgery and expect their surgery to commence at the appointment time given. Patients were not aware they may have to wait a long time for the surgery to commence after the initial contact and assessment.

Theatre utilisation at the PRUH location was provided to us in respect to the periods of May 2016 to May 2017. This information indicated that theatres were utilised an average of 77.27% for day surgery and 80% for main theatres.

Learning from complaints and concerns

Summary of complaints - PRUH

Between June 2016 and June 2017 there were 313 complaints about all services at the Princess Royal University Hospital. The trust took an average of 35 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 25 days.

We observed there was information available to patients and their relatives in raising a concern or making a complaint. Patients and relatives had access to the Patient Advice and Liaison Service (PALS).

Staff told us they were aware of the complaints process and feedback from complaints would be communicated to relevant wards. For example, staff told us about a formal complaint which related to a patient experiencing long waiting times for surgery, which indicated surgery waiting times...
required improvement. The service had been aware of the problem and concerns raised by patients. The service tried to improve the situation by creating the surgery admissions unit, to improve the patient flow and experience. Although the admissions unit had not reduced patient waiting times it created a better experience, by having private waiting rooms with a television and reading material for patients to use before going into surgery.

We were provided with information that weekly complaint review meetings had been held, which were chaired by the deputy managing director and/or the director of nursing. The meetings were designed to monitor progress of complaint responses and had improved the response rate. The complaint themes and trends were identified and discussed with the care group at this meeting.

A dedicated complaints manager had been appointed to Princess Royal University hospital and other south sites, to support the work of a revised governance and risk reporting structure, through which all care groups were required to formally present their complaints data and actions taken as a result of the complaints.

A total 113 complaints between September 2016 and September 2017 were received by the service and south sites surgery.

Of these, 52 complaints related to inpatients. The majority of these complaints, 22 in total, had been for the clinical treatment patients had received.

We were told that restructure plans and recruitment of staff would help to address the issues raised by the complaints.

At the PRUH there were 33 complaints for clinical treatment reported by patients and this was the highest amount out of all the complaint themes that were recorded. Admission transfers, transport, appointment delays and cancellations were the second highest with seven complaints respectively.

Is the service well-led?

Leadership

Senior leaders we spoke to told us they were committed to improving the standards of the service and understood their roles and responsibilities. The leadership structure included the director of nursing, a medical director and a deputy managing director. The organisation also included a general manager, clinical director and head of nursing for surgery, theatres and anaesthesia.

There had been changes in the leadership structure which provided clinical leads for each service and supported by service managers, since the last inspection to the benefit of the location and staff. The leadership team had implemented a restructure and a review of the service had been conducted. The purpose of the restructure was to provide a service to the local people that would improve the standard of care and to improve the overall performance of the unit. They told us that the changes introduced so far were well received by staff and there had been a positive response from all staff to the new improvements made within surgery.

Staff told us during our visit of the effective leadership and of being valued by senior management. They also told us they felt that the leaders had the skills and knowledge to perform their roles and were visible and approachable.

The senior management were able to explain to us the challenges the service faced and showed they were able to identify the actions needed to address these challenges. For example we were
told how bed capacity would be exceeded during winter months which would therefore result in operations to be cancelled. Although it was likely that this would occur again they felt with improvements made to patient flow this would help to reduce the number of operations that would need to be cancelled.

Staff at all levels told us they felt communication had improved both with immediate and senior management within the service since our last inspection. Matrons told us feedback from their staff indicated they felt supported and their opinions were valued by management on all levels. Nurses and health care assistants told us how they were able to speak to managers and senior management openly and honestly about any problems or issues they faced in their working or personal life.

There were plans to improve development programme by the senior management team to recruit staff from within the service to retain staff skills and knowledge. They also told us there were plans to recruit nursing staff to fill the current vacancies which will in turn reduce the pressure on staff and improve the care they provide to patients. We were told this would help to improve working conditions for staff, which in turn would help to retain existing staff.

**Vision and Strategy**

Staff were able to tell us about the vision of excellent care they wanted to provide to patients. We were told the vision was to put patients’ needs first, to be transparent in everything the service did and provide safe care that respected people’s needs. Staff told us this was due to the vision of the trust and how it had influenced staff to be committed to achieving this goal. Staff told us they felt involved and explained how feedback from staff and their opinions would be used to incorporate changes, to improve the overall care the service provided to its patients.

There was trust wide diversity and inclusion strategy which senior leaders plan to change and shape the culture and behaviour within the organisation as a whole. This plan had been designed to provide staff with the mechanism for their opinions to be heard. The plan includes clear branding to support diversity campaigns such as black history month celebrations and promote the equality calendar of events to create a culture of greater inclusion. There are three staff networks which the plan will aim to include and they are the Black Asian and Minority Ethnic (BAME) network, Disability Interest network and the Lesbian Gay and Bisexual Transgender (LBGT) forum. These networks had already been included on the trust website to promote and celebrate the diversity within the trust. All staff we spoke to mentioned they feel included in all aspects of their work regardless of their background or personal beliefs. The BAME network was launched on 14 July 2017 and the first PRUH BAME meeting had been scheduled for September 2017.

**Culture**

Staff on all surgical wards we spoke to told us they felt happy in the job they do. Staff we spoke with described an improved culture, with staff feeling able to share opinions through engagement directly with senior management. We observed there was an open culture and staff received positive and constructive feedback through newsletters and yearly appraisals. We also saw awards for individual staff and teams for outstanding achievement.

A number of staff told us they felt there was open culture within the service and were positive about the care and services they were able to provide for patients. An agency nurse told us ‘everyone’s opinions count’ and management had created a culture, where all staff regardless if they are agency of permanent were treated as equal.
Since the leadership team had come into place, staff had started to notice positive changes in their area of work. This included improved culture of honesty and open leadership and improved responses from management to their concerns.

One staff member said that due to budget restrictions, they were unable to make all the required changes they felt that were needed to be fully improve the service, but the culture now installed in management and staff, had been to continue to improve the service within their means.

A nurse who had worked at the service for four years told us there was a great team working ethic on the wards of surgery and matrons would often help if there were staff shortages.

**Governance**

It was evident that the service had taken steps to address the issues identified during our previous inspection; staff of all levels were all working towards the same goal of improving the surgery services for patients.

There were governance structures in place and staff felt they were effective. A monthly surgical quality and risk committee meeting was held every month and was attended by the head of nursing, ward managers, the risk manager and matrons. Incidents, root cause analysis and actions from the previous meetings were discussed and minutes of these meeting were recorded. Information provided by the service reflected this, we also saw evidence the head of nursing arranged teams who support surgery staff, such as the iMobile team to attend the meeting to discuss relevant topics such as deteriorating patient incidents.

We saw from information provided that serious incidents had been investigated within the governance and risk management structure. Information had been recorded in detail and discussed at the meetings to decide the correct course of action to be taken. Actions would be recorded and escalated and to be discussed in the next monthly meeting. We could see from the minutes recorded that learning from such incidents were also shared with staff through team meetings.

A Surgical Safety Improvement Group meeting every month. This was chaired by the trust lead in safer surgery, a consultant surgeon and CD in neurosurgery and included the patient safety manager, patient safety and governance officer and the general manager for surgery, theatres and anaesthetics. This meeting was also attended by the director of nursing and consultants, matrons and nurses. The aim of the meeting was to discuss relevant topics, review and improve all aspects of the service.

**Management of risk, issues and performance**

From information we reviewed there were 23 current risks on the risk register for surgery. One risk had the highest rating score of 20. A temporary arrangement had been planned to install new decontamination equipment in theatres, due to be signed off in June 2017. To date this had not been implemented and on 23/08/2017 the risk was reviewed and raised to a score of 25 and marked as on-going. Seven risks were considered as major risks and 15 as minor or moderate. On-going risks were updated and closed as the relevant action required.

Endoscopy decontamination was on the risk register when we inspected the hospital in 2015. Endoscopy decontamination was still on the surgical risk register when we inspected in September 2017 due to decontamination issues requiring a large number of procedure cancellations and the subsequent patient back log. Patients procedures were being cancelled as a result of the endoscopy decontamination issues.

**Engagement**
There was a long term view to improve the shared learning between surgery sites within the trust and attempts had already begun to change and improve this. Staff felt they belong to the same organisation and there was team mentality when staff spoke about the different surgery sites.

Patients and staff contributed to the running of the service and this was done by feeding back on their experiences through on-line and paper surveys. Patients and staff were also encouraged to share ideas through suggestion boxes and comment cards.

Information we viewed from minutes of meetings reflected communication had improved. New initiatives such as newsletters and intranet news site, helped to make staff feel involved with all areas of care within the hospital.

We observed patients and family members completing comment cards to feedback their opinions about the service and in particular the ward they visited.

Patients we spoke to felt staff communicated information in a professional and polite manner. They also felt they felt comfortable when speaking to staff who helped them to understand treatment and care plans which had been devised for them.

A nurse returning from maternity leave explained to us how she was provided with refresher training by her manager which included changes that had been implemented to her work duties, relevant ward information and any personnel changes that occurred during her absence. Staff felt informed on changes that affected them and felt included in changes made to their immediate working environments. For example implementation of the new training software installed by the service had improved the way staff record and monitor their training plans and how they access training courses available to them.

We spoke to a matron who told us on occasions she was required to do extra shifts on Saturdays and there had not always been not enough time to complete audits for the ward. The matron also advised staff do get tired but pull together and support each other to provide the best care to their patients.

**Learning, continuous improvement and innovation**

The service had planned and started to implement changes for continuous improvement.

We were told by staff about the King's way for wards which had been introduced as a new standard for the way all members of staff operated across the trust. It aimed to install a new culture of development, improvement and problem solving for all teams.

We were told the trust had introduced the ‘Perfect Ward’ application to be used to record data on a hand held device. The staff we spoke to were optimistic it would improve on current methods and the new tool had replaced the old paper based system. The new system had been introduced to reduce time spent by staff completing paper records.

An introduction of a new digital delivery system for patient correspondence was to be piloted of first appointment letters using text and web technology, but with a paper option still available for patients.

There were plans to trial of a new referral management software system which would allow patients to book when and where they can book an appointment.

A planned change to be implemented was the introduction of a new electronic document management system to enable historic paper records to be scanned and made available to clinicians digitally; this will help to reduce patient delays and will be available cross-site to reduce the need to transport paper documents.
Information provided referred to the implementation of virtual clinics and email advice inboxes, which would help patients avoid travelling to the service for appointments, which did not require physical examinations. This was to be done through digital media such as telephone or Skype.

A planned introduction of a patient portal clinical health record, which would be owned by the patient and could be accessed by care providers. The aim of this tool will be to allow the patient to be proactive in recovery and improve wellbeing.

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**Critical Care**

**Facts and data about this service**

The trust has 10 Critical Care beds at the Princess Royal University Hospital (the PRUH). The unit is funded for six level three beds and four level two beds. The unit has the ability to flex up to ten level three beds and opens two additional ‘satellite’ critical care beds in theatres recovery when it is at full capacity.

Between August 2016 and July 2017, 614 patients were admitted to the critical care unit (CCU). Most of the admissions were unplanned and patients were mainly admitted from the emergency department, wards or after urgent surgery.

Bed occupancy was consistently over 100% and by the time of our inspection, a business case had been approved for a five-bedded extension to the CCU.

We visited the CCU and theatre recovery area over the course of two unannounced inspection days. During our inspection, we spoke with 17 members of staff including consultants, doctors, nurses, allied health staff and domestic staff. We spoke to eight patients and relatives who were using the service at the time of our inspection. We observed care and treatment and looked at seven patient records and medication charts.

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**Is the service safe?**

**Incidents**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Critical Care.

Staff reported 81 incidents in Critical Care between 1 May 2017 and 31 August 2017. Eight incidents were in relation to the iMobile (critical care outreach) service while, 73 were in relation to incidents on the CCU. Each incident was classified according to the severity of the incident. Sixty-eight incidents were classified as “no harm”, seven were classified as “minor injuries or illnesses”, one as moderate injury or illness, and 13 as “prevented or avoided harm”. The incidents included one red incident requiring root cause analysis (RCA) report. The red incident had occurred in the month preceding our inspection and the trust informed us it was currently under investigation.

Compared with findings from our last inspection in 2015, learnings from incident was consistent. We reviewed two RCA reports from September 2016 and November 2016 and found appropriate
investigations had taken place. We found the trust had identified the root causes, analysed the contributing factors to the incident and identified actions to reduce the risk of similar incidents occurring in the future.

For example, following a medication error staff involved had reflected on the incident and learnings were disseminated to all staff. We observed that staff displayed information about incidents and trends on notice boards within the CCU.

There were no serious incidents reported in the last 12 months.

Staff at all levels were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit. Learnings from incidents were shared during handovers, team meetings, on staff notice boards and via emails. Staff understood their responsibility under the duty of candour regulations and we saw examples of the correct process being followed from our review of RCA reports.

We reviewed the notes of mortality and morbidity (M&M) meetings in the last three months before our inspection and found that they were informed by a deceased patient summary. Minutes of the M&M meetings indicated that areas of learning were identified and actions from the meetings were specified.

The CCU conducted daily safety briefing with the consultant, nurse in charge and iMobile (critical care outreach) staff in attendance. Staff discussed each individual patient and their treatment plan.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Information received from the trust indicated this method of collecting patient safety related data was no longer used. In its place, the trust was using a ‘Perfect Wards’ system. This was a weekly audit looking at a range of indicators such as infection, prevention and control (IPC); staffing; falls and pressure ulcers.

The CCU displayed clear, easy to read “safety data” for staff, patients and visitors. It showed that between May and July 2017, there was one incident of hospital acquired pressure ulcer (HAPU) reported on the CCU. There were no incidents of falls reported. The pressure ulcer incident involved was an unstageable pressure sore to the ear. The incident record showed a tissue viability nurse reviewed the patient and documented a plan for staff to follow. Information from the trust indicated the investigation had not yet been completed. However, senior staff informed us the sore had healed by the time of our inspection.

Our review of patients’ notes showed that all patients had their level of risk assessed for venous thromboembolism (VTE), falls and pressure ulcers. Staff reviewed these risks at regular intervals. Staff informed us tissue viability nurses reviewed patients with pressure ulcers and we saw their input within the patient notes reviewed.

The CCU participated in “Commit to Care” an assessment and accreditation system based on a number of clinical outcomes. It specifically looked at the environment and leadership of the ward area. Wards were accredited on a score of zero (lowest level) to gold, Level 3 (highest level). The CCU was awarded gold and scored 100% in manual handling/falls.
Cleanliness, infection control and hygiene

All areas of the critical care unit were visibly clean. Other areas within the unit, such as the relatives waiting area, quiet room, toilets, the sluice room and nursing stations were visibly clean and tidy. Patients and relatives were satisfied with the level of cleanliness on the unit.

The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids.

There was easy access to personal protective equipment (PPE). Aprons and gloves were available in all areas we inspected and we observed staff using PPE as required. There was also sufficient access to handwashing and drying facilities. The CCU displayed signage prompting people to wash their hands and have guidance on good hand washing practice. We observed bed space curtains were labelled and dated when they were last changed.

Staff were ‘bare below the elbow’ and staff adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.

Where patients had a known or suspected infection, they were nursed in single side rooms. There were three side rooms on the CCU.

Each side room in use had signs displaying presence of infection, which meant staff, and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed to these areas. We saw there were leaflets available for patients about infection control and isolation. These provided details about the purpose of isolation and what was required.

There were housekeeping staff for cleaning wards and cleaning staff understood cleaning frequency and standards. Green ‘I am clean’ stickers were used to identify which equipment staff had cleaned and which were ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned. We observed staff promptly cleaning a bed area following a patient’s discharge to the ward.

Waste management, including those for contaminated and hazardous waste was generally in line with national standards.

Needle sharp bins were available on the unit. Sharp bins were correctly labelled and none were filled above the maximum fill line.

The unit had access to an infection control link nurse and microbiology staff conducted clinical rounds daily.

Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns with hospital-acquired infections and performance in these areas was better than in comparable units. The CCU safety data showed that between May and July 2017, there was one incident of Clostridium difficile (C.diff) infection. There was no incident of MRSA reported during the same period.

The unit audited compliance with cleaning and hand hygiene guidelines every month. Between May 2017 and July 2017, the CCU achieved an overall score of between 96 and 98% for compliance with cleaning standards. During the same period, staff compliance with hand hygiene
standards was about 95%. The table below provides a breakdown of cleanliness and hand hygiene scores.

<table>
<thead>
<tr>
<th>Audit</th>
<th>PRUH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May-17</td>
</tr>
<tr>
<td>Cleaning audit overall score Estates, domestic &amp; nursing</td>
<td>96-98%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>%</td>
</tr>
</tbody>
</table>

Overall, 97% of nursing staff had completed the infection prevention and control (IPC) training across the critical care unit. This was higher than the trust’s target of 85% for mandatory training.

The CCU scored 100% in the “Commit to Care” assessment for environment and infection.

**Environment and equipment**

The CCU was a 10-bedded unit consisting of seven beds and three side rooms. The seven bed spaces within the main critical care area were suitably spread out and there were three side rooms adjacent to the main ward area.

The CCU used two beds in the theatre/recovery area as an escalation area for up to two patients when they exceeded capacity. These beds were not suitably spread out to meet the requirement for critical care units. However, there was an escalation policy in place to mitigate risks arising from the use of the escalation area. Staff informed us patients admitted on the escalation area were usually low dependency and close to stepping down from the unit. As at the time of our inspection, the trust had approved plans to extend the CCU with additional five-beds by summer 2018.

Staff maintained a reliable and documented programme of equipment checks. Nursing staff on all units had maintained resuscitation equipment with daily documented checks. We observed resuscitation equipment was readily available on the units. Difficult airway and emergency tracheostomy equipment was available on the unit. We found that the resuscitation trolley and difficult airway trolley was regularly checked and compliant with the Resuscitation Council guidelines.

The CCU at the Princess Royal University (PRUH) did not have technical support like other CCUs at Kings College Hospital, Denmark Hill. This meant staff were sometimes unable to access immediate support for repairs. A Band 8a lead technologist covered both sites and attended the CCU at the PRU once a week. New technicians were appointed by September 2017 to rotate between the sites. The service was also recruiting for a band 6 technician to be located on the PRUH site.

The CCU had recently purchased new equipment including arterial blood gas analysers (ABG) ventilators, ultrasound machines and pulse contour cardiac output (PICCO). Staff informed us they had received training to use equipment and machinery.

We observed medical gases where stored in a separate room, however, this room was unlocked and accessible to unauthorised individuals.

**Medicines**

Medicines management on the CCU had improved, as medicines were generally stored safely and securely. All drug storage cupboards were securely locked and regular audits were completed regarding the accuracy of controlled drug documentation and medicines management. We
observed that IV fluids were stored in an open area behind the nursing station. Senior staff informed us this was for ease of access. This was on the CCU risk register and mitigating controls were in place. The fluids were stored in an area predominantly used by staff and visible to all staff on the ward. In addition, fluids were wrapped in packaging and staff discarded unwrapped fluids.

A temperature checking system was in place for refrigerated medicines and fridge temperatures were monitored daily. We observed one gap in daily fridge temperatures checks on 11 September 2017. We checked a random sample of medication and all medication were in date.

We reviewed seven patient records which included medication administration records (MAR) and saw they were completed accurately and signed by staff. In addition, staff documented reasons for any missed doses. Staff appropriately documented allergies and medicine reconciliations. A pharmacist verified and documented additional administration instruction. There were instructions on notice boards with information about checking patient allergies.

A pharmacist attended a daily review of each patient and reviewed each patient’s medications to ensure that they were suitable and within prescribing guidelines. Staff reported good support from the pharmacy team and pharmacists attended multidisciplinary team meetings.

All drug errors were discussed at risk and clinical governance meetings. Senior nursing staff also attended a critical care medication safety group which encouraged cross-site learning with staff from them Denmark Hill site.

The trust conducted quarterly controlled drugs (CD) audit to ensure staff adhered to set standards. The standards included the following requirements; “keys to be kept securely”, “full details at the top of each CD register page”, “stock levels tally with CD book”, “balance carried forward is recorded”, “each entry is complete”, “errors not obliterated and countersigned”, “unwanted/expired CDs returned correctly”, “storage of CD record books secure”, and “authorised person has ordered the CDs”. Each department’s compliance with CD audit was highlighted in green for 100%, amber for 90-99%, and red for 89% and below.

Results for the first quarter of 2017/18 showed the CCU was compliant with seven of nine standards. However, it was rated amber for standards requiring “full details at the top of each CD register page” and “stock levels tally with CD book”.

Following the inspection, the trust informed us all CCUs had submitted a list of authorised signatories for CDs to the pharmacy. Each unit checked the CDs after each shift to ensure all standards were met and documentation was complete and accurate. They informed us all areas were now fully compliant.

A report on the antimicrobial stewardship audit for the PRUH (July 2017), showed that the CCU scored 100% against the trust’s established guidelines for antimicrobial prescriptions.

Medication training records for nursing staff showed that 95% of staff had completed the training.

The CCU scored 100% in the “Commit to Care” assessment for medication.

**Records**

The CCU used paper-based records. Staff demonstrated a good understanding of the need for confidentiality and we observed that staff kept patients notes in a secured locker on the unit.

Each patient on the CCU had a critical care patient safety analysis (CCPSA) booklet. This contained details such as falls risk assessment, psychosocial assessment checklist and information about mental capacity and deprivation of liberty safeguards (DoLS).
We looked at a random sample of seven patient notes on the CCU and saw improvements made since our inspection in 2015. All the records we looked at included details of allergies, a daily treatment plan, and record of daily consultant reviews. Staff recorded specialist assessments, including assessments for nutrition, neurology and respiratory needs. The records showed input from multidisciplinary team including physiotherapists, dietitians, and the tissue viability team. In addition, the records demonstrated consultants reviewed patients on admission to the unit and that daily consultant led ward rounds took place. All medical and nursing notes reviewed were completed, dated and signed.

The unit scored 100% in the “Commit to Care” assessment for documentation.

Safeguarding
Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Staff said the team members were visible and approachable. Staff escalated safeguarding incidents to the safeguarding team. They could also report safeguarding incidents using an electronic system.

Our review of patients’ notes showed that staff completed psychosocial assessments in the CCPSA booklet with prompts to identify any safeguarding concerns.

The trust set a target of 80% for completion of safeguarding training.

Ninety-eight per cent of nursing staff had completed the safeguarding adults training. Ninety-two per cent of nursing staff had completed the safeguarding children training.

The CCU scored 98% in “Commit to Care” assessment for safeguarding.

Mandatory training
The Critical Care Unit had a dedicated practice development and education team. A practice development nurse (PDN) was attached to each ward.

Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice. Staff confirmed they received reminders from PDNs when due for an update. Staff also had access to their training records which was colour coded to highlight upcoming training.

A breakdown of compliance with mandatory training is shown below:

Nursing Staff:

<table>
<thead>
<tr>
<th></th>
<th>Aseptic Non Touch Technique (ANTT)</th>
<th>Blood</th>
<th>Conflict resolution</th>
<th>End of Life</th>
<th>Fire</th>
<th>Infection Control</th>
<th>Information Governance</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRUH CC %</td>
<td>100</td>
<td>97</td>
<td>100</td>
<td>100</td>
<td>97</td>
<td>98</td>
<td>97</td>
<td>98</td>
</tr>
</tbody>
</table>

Resuscitation  Safeguarding Adults  Safeguarding Children  Slips, trips and  VTE
Nursing staff exceeded the trust’s target of 80% for all mandatory training modules. This was an improvement from the last inspection when there were low completion rates for some modules including ANTT, information governance, mental capacity and VTE. Information from the trust indicated mandatory training records for medical staff included anaesthetics and pain departments. Mandatory training records were not split for CCU medical staff.

Assessing and responding to patient risk

The critical care outreach service (iMobile) was providing 24 hours, seven days a week response to deteriorating patients. The service was provided by experienced band 7 critical care nurses. iMobile staff informed us there was one staff on shift majority of the time with two on shift when there was a cross over. Staff confirmed they had medical support when required. The team provided rapid response, stabilisation and transfer for patients needing immediate attention. The team provided follow up for patients discharged from critical care. It provided outreach advice and education for patients who were acutely ill not yet needing admission and mobile critical care interventions for patient on wards.

There was an iMobile escalation protocol, which set out algorithms for escalating patients to the team. Staff on the ward used the national early warning score (NEWS) to identify patients whose condition was deteriorating. iMobile staff were alerted and monitored if patients were deteriorating to the level that they needed to review their treatment. Any patient potentially needing escalation of care required a review by iMobile first.

Data from the trust showed that the mean time (minutes) to review following referral to the iMobile team was 15 minutes in July 2017 and 31 minutes in August 2017.

CCU staff used the Glasgow Coma Scale (GCS) to assess the patients’ conscious level and the Richmond Agitation-Sedation Scale (RASS) to measure agitation of an unconscious patient (RASS is used in ventilated patients in order to avoid over and under-sedation).

Staff evaluated patients using the Confusion Assessment Method for the ICU (CAM-ICU) flowchart to determine whether delirium was evident. The CAM-ICU had been integrated as part of the daily care plan for patients.

iMobile staff reviewed patients upon discharge from the CCU.

Each bed area within the critical care unit had a patient board with clear information about the staff looking after each patient, expected date of discharge and patient safety alerts such as their allergies.

The CCU scored 100% in the “Commit to Care” assessment for patient observations.

Nursing staffing
A matron led nursing staff on the CCU. We observed that the nurse in charge of the CCU was supernumerary in line with Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) standards.

There were 10% nursing staff vacancy at the time of our inspection and bank/agency staff were used to fill gaps in the rota. Senior staff informed us bank/agency staff were inducted to the unit. Bank staff used were PRUH staff working additional shifts. Senior staff informed us they used regularly booked agency staff that had experience of the unit.

An acuity tool was used to determine staffing levels. The FICM core standards for Intensive Care Units states that all level three patients (patients who need advanced respiratory support alone, or basic respiratory support along with support of at least two other organ systems) are required to have a registered nurse to patient ratio of minimum 1:1 to deliver direct care. For level two patients (patients who needed higher levels of care and more detailed observations or interventions, such as single organ support) a ratio of 1:2 was required.

We observed that nurse-staffing levels were in line with the national guidance on the days of our inspection. The CCU had 1:1 nursing care for level three patients and at least 1:2 nursing care for level two patients. We found nurses stationed at patient’s bedsides most of the time.

The safety data displayed on the unit showed there were 11 nurses on shift on the first day of our inspection. Established staff for the shift were 12 nurses and one health care assistant (HCA). There were 10 nurses and one HCA on shift against an established level of 11 nurses and one HCA on the second day of our inspection. The number of nursing staff on shift was sufficient for the acuity of patients on the unit.

The iMobile outreach team was staffed by one band seven nurse during the day and during night shifts. They received support from CCU doctors.

Details of CCU staffing levels are provided in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Establishment</th>
<th>Actual</th>
<th>Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRUHCCU</td>
<td>62.41</td>
<td>56.34</td>
<td>6.07</td>
</tr>
<tr>
<td>6.9</td>
<td></td>
<td>5.9</td>
<td>1</td>
</tr>
<tr>
<td>PRUH iMobile</td>
<td>6.9</td>
<td>5.9</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>69.31</td>
<td>62.24</td>
<td>7.07</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>10.20</td>
<td></td>
</tr>
</tbody>
</table>

Evidence from the critical care scorecard showed a high level of reliance on bank and agency staff as shown below:

<table>
<thead>
<tr>
<th></th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-16</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank and agency</td>
<td>6.6</td>
<td>3.95</td>
<td>6.5</td>
<td>5.57</td>
<td>11.7</td>
<td>8.31</td>
<td>11.15</td>
<td>9.88</td>
<td>11.19</td>
<td>6.14</td>
<td>4.09</td>
<td>7.5</td>
</tr>
<tr>
<td>Bank WTE</td>
<td>2.2</td>
<td>1.8</td>
<td>2.6</td>
<td>1.59</td>
<td>5.1</td>
<td>6.21</td>
<td>6.79</td>
<td>7.9</td>
<td>8.56</td>
<td>5.64</td>
<td>4.09</td>
<td>7</td>
</tr>
<tr>
<td>Agency WTE</td>
<td>4.4</td>
<td>2.15</td>
<td>3.9</td>
<td>3.98</td>
<td>6.6</td>
<td>2.1</td>
<td>4.36</td>
<td>1.98</td>
<td>2.63</td>
<td>0.5</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>Staff deficit for acuity/WTE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.09</td>
<td>3.7</td>
<td>1.2</td>
<td>1.1</td>
<td>0.65</td>
<td>0.27</td>
<td>0.07</td>
<td>0</td>
<td>0.66</td>
</tr>
</tbody>
</table>

The critical care scorecard showed bank staff filled most gaps in the five months prior to the inspection.
Nursing staff conducted handovers twice daily with the whole team in the morning and in the evening. We observed a handover on CCU and found them to be structured, detailed and with a focus on personalised care. Nursing staff received an overview of all critical care patients at the start of their shifts and then a thorough bedside handover once they were allocated a patient. Handover sheets were comprehensive and there were discussions about patient’s social and medical history, their treatment plan and details regarding current observations.

**Medical staffing**

A clinical lead consultant led medical staff on the CCU at the PRU. Medical staffing consisted of eight consultants, five associate specialists, one clinical fellow and five speciality doctors. In addition, there were 15 other junior doctors of various grades.

Between June 2016 and May 2017, the trust reported a vacancy rate of 20% for medical staff. This exceeded the trust’s target vacancy rate of 8%. Senior medical staff confirmed they used locums who had previously worked at the trust to fill gaps in rotas.

The Guidelines for the Provision of Intensive Care Services (GPICS) recommends the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the CCU resident/patient ratio should not exceed 1:8. The consultant/patient ratio was in line with the recommended national guideline with one consultant rostered to cover the critical care unit.

Consultants worked shifts from 8am to 8.30pm, supported by a CCU registrar and a junior doctor. Consultants were on-call overnight, with a required response time of 30 minutes.

There was one CCU register covering the unit and referrals overnight, therefore exceeding the recommended GPICS ratio of 1:8 resident/patient ratio. The CCU doctor usually had a high workload reviewing deteriorating patients on the wards, attending cardiac arrests and being available on the unit, including the escalation area.

The issue with insufficient medical staffing was on the risk register. By September 2017, a business case to recruit additional medical staff had been approved.

We observed a medical handover on the CCU. Consultant led medical rounds were appropriate, with a full review of each patient’s history, medicines and treatment.

**Major incident awareness and training**

The major incident policy was up to date and had appropriate action cards for critical care staff on how to act in the event of an emergency. These included options for increasing level three bed capacity as well as options for creating level two capacity.

**Is the service effective?**

**Evidence-based care and treatment**

There were clear policies and procedures in line with best practice guidelines. This included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations. Staff had access to guidelines on the trust’s intranet system. In addition, there were guidelines for day-to-day bedside activities attached to each patient’s trolley. These included guidance for removal of arterial lines, gentamicin dosing, weight based dosing, therapeutic drug monitoring, flow chart for patients admitted with pressure ulcers, flow chart for bowel management, enteral feeding flow chart and peripherally inserted central catheter (PICC) line top tips amongst others.

The CCU was part of the South London Adult Critical Care Operational Delivery Network (SLACCN). The network’s peer review report dated June 2017 highlighted the CCU’s performance
against Critical Care Service Specific Standards (D16) 2015. It showed that whilst the service fully or partially met most of the standards, there were several areas of concern. The CCU did not meet standards pertaining to the maintenance of equipment due to the lack of technical support on site. However, by the time of our inspection, the trust had recruited technicians to rotate across sites including the CCU at the Princess Royal University Hospital (the PRUH). There were also concerns regarding staffing and meeting physical rehabilitation needs for patients.

The trust informed us they were putting an action plan in place to address areas of concern highlighted in the recent SLACCN peer review report. They had submitted a business case for additional funding to support allied health staff services.

The CCU achieved a gold rating in the trust’s “Commit to Care” initiative, an assessment and accreditation system based on a number of clinical outcomes. Wards were accredited on a score of zero (lowest level) to gold, Level 3 (highest level). The CCU scored 100% in the “commit to care” assessment for ventilator care bundles.

The Critical Care Unit (CCU) contributed 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 across the UK.

There was a local audit programme in place to ensure certain audits were completed monthly such as ventilator-associated pneumonia (VAP) prevention care bundle audits and venous thromboembolism (VTE) assessment audits.

Information displayed within the CCU showed results for VTE assessment and prophylaxis between April and July 2017. The result showed 100% score for risk assessments completed on admission, 90% score for daily re-assessment, 100% for correct assessment and 100% for appropriate prophylaxis.

The CCU completed monthly VAP audits. Results from the audit between February 2017 and July 2017 show VAP completion rates had improved overtime. The CCU scored 60% in February 2017, 90% each month from March 2017 to May 2017, and 100% in June and July 2017.

We observed appropriate sepsis management from reviewing patient notes and staff administered antibiotics in line with guidelines. We also observed that staff measured patients’ rehabilitation progress using the Chelsea Critical Care Physical Assessment tool (CPAx).

**Pain relief**

Our review of patient records showed that staff used a standardised scoring tool to assess patients’ pain and recorded pain assessments in patients’ notes. The Critical-Care Pain Observation Tool (CPOT) for non-communicating patients rates critically ill patients’ pain based on clinical observation. We observed the CPOT tool was in use on the CCU. Pain assessments were completed and pain scores recorded.

Patients also told us they received pain relief when they required it and that it was reviewed regularly.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool 'MUST' is a validated nutritional screening tool and is the most commonly used tool throughout the UK. It is a simple five-step tool designed to identify adults at risk of malnutrition and to categorise than as being at low, medium or high risk. Our
A review of seven patient records showed that staff completed nutrition and hydration assessments for each patient. Enteral nutrition plans and food charts were in place and completed.

We observed fluid monitoring in place for patients, which demonstrated hourly and daily fluid input and output totals.

Staff confirmed they had access to dietitians and could refer patients to them when necessary.

The CCU scored 100% in the trust’s “Commit to Care” assessment for nutrition.

**Patient outcomes**

The ICNARC data showed the CCU risk adjusted hospital mortality ratio was 1.10. This was within the expected range for the unit. The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.16. This was also within the expected range for the unit.

Unplanned readmissions to the CCU within 48 hours of discharge (2.9%) were higher than similar units (1.2%). Non-clinical transfers to another unit (0.9%) were higher in comparison to similar units (0.6%) but within the expected range for the unit.

The mean length of stay on the CCU was 4.7 days, which was better than the average for similar units (5.3).

ICNARC data from April 2016 to March 2017 showed there were 110 deaths. This represented a mortality rate of 18%, which was just above expected mortality rate.

(Source: Intensive Care National Audit Research Centre (ICNARC) - 20 July 2017 (1 April 2016 to 31 March 2017))

**Competent staff**

There was one full-time Practice Development Nurse (PDN) for the critical care unit, in line with the FICM standards. The practice development team monitored nurse competencies to make sure they were up to date with current practice based on national benchmark standards. Staff confirmed they received reminders to update their training.

The Faculty of Intensive Care Medicine (FICM) 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. At the time of our inspection, 63% of nurses had post registration qualifications in critical care and 65% of nurses had completed a mentorship course.

There were systems to ensure staff were competent to carry out their role. New nurses went through a three-week supernumerary induction period to ensure they were familiar with local policies and procedures. They were allocated a mentor and were required to complete competency-based assessments before they were allowed to work without supervision. New nurses were able to undertake the post registration qualification in critical care following 12 months critical care experience. The post registration programme was undertaken in house and accredited by the ICS.

Staff confirmed they received adequate training to carry out their role including training in the use of equipment. Staff confirmed they had regular supervision and yearly appraisal. They said they were given allocated time for study days and training.

Nurses said they were well supported by senior staff to care for patients and were allocated patients they could cope with.
There were eight consultants on the unit. All critical care consultants had additional intensive care qualifications.

New doctors received an orientation and induction programme following their employment. Each doctor was allocated a clinical supervisor and completed a clinical competency checklist.

Junior medical staff were mainly staff grade doctors who had worked on the unit for a long time. There were also doctors on rotation to the unit as part of their on-going training programme. Medical staff had protected time for teaching as well as bedside teaching from consultants during ward rounds.

The lead consultant monitored the training and audit programmes of doctors to ensure they implemented learning to improve practice. Medical staff used regular meetings, such as M&M and governance meetings with the critical care delivery group to review practice guidelines and identify areas of good practice and areas of improvement. Junior doctors we spoke with were happy with the training and teaching they received in critical care.

**Multidisciplinary working**

Staff reported good working relationships with other teams. Our review of seven patient records showed there were input from physiotherapists, pharmacists, dietitians and speech and language therapists (SaLT).

Senior staff reported they had good working relationships with other local trusts. In addition, the critical care post registration course was delivered in partnership with a local trust.

The CCU was part of the South London Adult Critical Care Operational Delivery Network and staff from the trust attended network meeting to share practice and learning.

A daily board round was held on the unit which was a short patient briefing and an opportunity to make or receive multidisciplinary referrals. This was attended by medical staff, pharmacy, physiotherapy and dietetics.

Staff reported good working relationships with allied health professionals (AHPs) including pharmacists, physiotherapists, occupational therapists, SaLT and dietitians. However, we found therapy provision on the CCU was not compliant with Guidelines for the Provision of Intensive Care Services (GPIS).

AHP coverage consisted of 1.26 WTE physiotherapy staff, 0.46 speech and language therapy staff (SaLT) and 0.5 WTE dietetic staff. This meant physiotherapy staffing was at a ratio of 0.04 per bed instead of 0.25, SaLT staffing was at a ratio of 0.04 per bed instead of 0.15 and dietetic staffing was at a ratio of 0.05 per bed instead of 0.1.

The pharmacy team consisted of a band 8b and band 7 pharmacists. A pharmacist attended a daily review of each patient and reviewed each patient’s medications to ensure they were suitable and within prescribing guidelines.

**Seven-day services**

Medical and nursing staff provided cover on the CCU for 24 hours a day, seven days a week.

Consultants were present on the CCU for 12 hours a day and on call overnight within 30 minutes of the hospital reach. There was a registrar available 24 hours each day and they were supported by junior doctors during long day shifts.

Critical care pharmacy service was available from Monday to Friday.

Staff reported good access to imaging services out of hours or at weekends.
Therapist provided mainly weekday services and a dietitian conducted ward rounds to review patient’s nutritional statuses.

**Access to information**

Staff received a verbal and written handover when patients were admitted to the ward.

Formal handover documentation was in place for patients being stepped down or discharged from the unit.

Staff had access to patients’ paper records. Our review of patient notes showed they were comprehensive and included details of each patient’s medical history, GP and personal information details, assessments and test results.

There was access to professional guidance, policies and procedures. Staff also received information with regard to learning from adverse events and changes in professional practice.

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

Staff had access to mental health/deprivation of liberty safeguards guidelines on the trust intranet. Staff were able to talk about the deprivation of liberty safeguards (DoLS) and how this would impact a patient on the unit. Staff were aware of their responsibilities under the mental capacity act.

Our review of patient notes showed that staff completed neurological assessments with prompts to identify issues that may affect mental capacity. Consent forms were completed in line with established guidelines. Where a patient was unable to consent, relatives were duly consulted and best interest forms were signed.

Staff were required to complete restraint forms anytime mittens were used to prevent patients from accidentally removing intravenous lines and ventilator tubes. Restraint forms were required to be signed off by a consultant and we saw proforma restraint forms were included in patient’s records. At the time of our inspection, no patients were subject to DoLS and so there was no documentation to review.

CCU training records show that 98% of nursing staff had completed the Mental Capacity act training.

The trust had achieved Accreditation for Inpatient Mental Health Services (AIMS) including Psychiatric Intensive Care Units (PICU).

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**Is the service caring?**

**Compassionate care**

Patient, family and friends feedback on all the wards were mostly positive. Patients and their relatives described care as “pretty good” and “amazing”. They said staff were “fantastic”, “respectful”, “very friendly” and “really nice”. Relatives said they were happy with the care provided on the unit.

All observations of care we made were positive, showing kind and compassionate care. We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing the curtains around patient areas before completing care tasks. Staff confirmed they were satisfied with the level of care they provided to patients.
The CCU participated in the trust’s “Commit to Care” initiative, an assessment and accreditation system based on a number of clinical outcomes. The unit scored 100% in the assessment for privacy and dignity.

Between July 2016 and June 2017, the results of the NHS friends and family test showed that 99% of patients would recommend the CCU.

Understanding and involvement of patients and those close to them

Patients we spoke with confirmed staff introduced themselves, explained procedures and obtained their consent before conducting them. Relatives also confirmed that they were informed about patient care. One relative said they have not had to chase up information and they were kept up to date with the patient’s care.

Specialist nurses for organ donation worked closely with the chaplaincy team to support families when their relative had been identified as dying and suitable for organ donation. Some of the relatives we spoke with confirmed they had been in contact with the organ donation team. They confirmed that staff had been supportive and reassuring in their conversations with them.

Emotional support

Staff provided emotional support to patients and their families routinely. Feedback from patients and relatives were positive and they told us staff had been reassuring and comforting.

Our review of patient notes showed that staff completed psychological assessments as well as psycho-social assessments to determine the needs of each patient. We observed there were prompts within psycho-social assessments to provide families with leaflets and relevant information following bereavements. Bereavement and counselling could be assessed via a referral from the CCU.

Staff could provide information about additional external support networks if required by the patient or their relatives. The unit had a follow up clinic to support patients recovering from illness.

Senior staff informed us they assessed patients for anxiety and depression as part of the doctors’ daily ward round.

Emotional support was also provided by the multi-faith chaplain service within the hospital and representatives from various faith groups could be accessed.

Is the service responsive?

Service planning and delivery to meet the needs of local people

The CCU had clear admission guidelines and the guidelines were in date. The consultant on shift usually agreed admission to critical care. For emergency admissions, a referral to critical care was made through the iMobile (critical care outreach) senior nurse and/or the critical care consultant. Patients undergoing high-risk major surgery were booked into the CCU prior to the day of the planned procedure. The CCU consultant made the decision to proceed with elective admission considering the bed capacity, discharges and emergency admissions.

The Intensive Care National Audit and Research Centre (ICNARC) data from April 2016 to March 2017 showed the CCU’s main sources of admission were from the ward or intermediate care area (38%), the emergency department (34%) and theatre (27%).
The trust’s critical care activity data showed that most of the admissions to the CCU were unplanned. Over 60% of patients admitted in between August 2016 and July 2017 required level 3 support whilst the remaining patients required level 2 support.

The critical care unit had been at over 100% bed occupancy in the last 12 months. Senior staff recognised capacity as the main risk on the unit and existing facilities were insufficient to meet the demands for the unit. To this end, the trust had approved plans for a five-bedded extension to the CCU. Senior staff informed us the additional beds would be available by next year.

Patients had access to a follow up clinic after they were discharged from the CCU. Discharge summaries from the CCU were sent to family doctors (GPs). The follow up team liaised with GPs to arrange counselling, psychiatric support, rehabilitation services and other clinical services.

Relatives had access to two visitor’s rooms on the critical care unit. There was a private visitor room for discussing confidential information with relatives. The room was equipped with a sink and storage cabinet. In addition, visitors had access to a book cupboard in the room. A larger visitor’s room had been created since our last inspection in 2015. The room was spacious and relatives had access to a toilet close to the visitor’s room. There were several cafes within the trust’s premises accessible to all visitors.

(Sources: ICNARC – 6 June 2017)

Meeting people’s individual needs

On admission to the unit, patients and their relatives were given a CCU information leaflet outlining key information and what to expect. Other information leaflets were available for visitors in the entrance corridor and in visitor’s rooms.

Staff confirmed that they could access interpreting service for patients through a help line. They could also request for face-to-face interpreting services when required.

Patients were provided with a menu with a variety of meals to choose from. Food menus offered a range of options including softer choices, vegetarian, kosher amongst others. If a patient had any specialist dietary requirements staff would record this. Patients were enabled to eat independently and drinks were placed within their reach. We observed nurses assisting patients when required.

Visiting hours were 2pm – 7pm daily. Visiting times were flexible outside of the advertised hours, so friends and family could visit when it was convenient for them. We spoke with relatives, who told us they had been allowed to visit outside of the advertised hours due to their family circumstances.

Some of the relatives we spoke with said staff checked to see if they were comfortable and offered them tea and coffee. They felt it would be better if there were facilities for drinking water and beverages in the visitor’s room. This would prevent nurses from having to ask them what they needed all the time.

Patients had easy access to chaplains and we saw chaplains visit patients on the unit.

Patient’s mental health status was recorded and staff could make referrals to a psychiatric team where necessary.

Staff completed psychosocial assessments, which included prompts to identify any safeguarding concerns. Staff reported safeguarding concerns to the safeguarding team and could make referrals to social workers.
Staff assessed family needs from admission documents and proactively arranged support for families. For example, long-term arrangements were often made to cover car parking costs. One of the relatives we spoke with confirmed they had been provided with assistance with parking cost.

We observed physiotherapy staff helping a patient to walk along the corridor as part of their rehabilitation programme.

We observed staff using communication aids (a speech board) to communicate with a patient.

Staff assessed patients’ learning disability (LD) needs and referred them to the LD team for additional support where necessary.

There were leaflets on a variety of topics including links to a dementia support hub, chaplaincy service, the complaints procedure, organ donation, blood transplant, friends and family test questionnaire and infection control.

Mixed sex breaches had occurred frequently over the last year. A mixed sex breach occurs when level one or zero patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. Due to the lack of beds within the hospital, patients from the CCU were not always discharged in a timely manner leading to these breaches occurring. There were 165 incidents of mixed sex breaches in the CCU in the last year, an average 13 mixed sex breaches per month.

It was not clear how patients living with dementia were identified and we did not see evidence of any relevant documentation in the patient notes.

**Access and flow**

The CCU was funded for six level three beds and four level two beds, but had the flexibility to accommodate 10 level three patients.

Our review of patient records showed that most patients were admitted within four hours of the decision to admit being made. Data from the trust showed there was one delayed admission out of 61 unplanned admissions to the CCU between June 2017 and August 2017.

The trust’s critical care activity data showed that between August 2016 and July 2017, the average bed occupancy rate on the CCU was 106%. These occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency.

To mitigate the demand on the service, two additional beds were often used in the theatre recovery area. These beds were staffed by critical care nurses. Between August 2016 and July 2017, staff cared for an average of 13 patients in this area each month.

Senior staff said they had good working relationship with the site management team to manage patient flow. In addition, the iMobile team worked with nurses on the ward to proactively manage early signs of deterioration in patients in order to avoid admissions to the critical care units.

The trust held bed meetings three times a day at the Princess Royal University Hospital. Staff discussed the number of possible discharges and admissions for the day to facilitate patient flow across the hospital.

Data from the trust showed there were 320 (51%) delayed discharges (greater than four hours) from the CCU in the 12 months between August 2016 and July 2017.
ICNARC data showed there were 3650 available bed days from April 2016 to March 2017. The percentage of bed days occupied by patients with discharge delayed by more than eight hours was 6%. This compares to the national average of 5%. This meant the unit was not in the worst 5% of units nationally. The percentage of bed days occupied by patients with discharge delayed by more than 24 hours was 3.6%. This compares to the national average of 3%.

Patients discharged from critical care ‘out of hours’ between 10pm and 7am are nationally associated with worse outcomes. ICNARC data from April 2016 to 31 March 2017 showed that 15 (3.6%) patients on the CCU were discharged ‘out of hours’. This compares with 2.5% for similar units.

ICNARC data showed non-clinical transfers out of the CCU was 0.9%. This compares to the national average of 0.4%.

Data from the trust showed eleven elective surgeries were cancelled in the last 12 months due to lack of critical care bed on the CCU.

(Source: ICNARC – 6 June 2017)

Learning from complaints and concerns

Staff informed us that they escalated complaints to their managers and also directed patients and relatives on how to make complaints and referred them to the Patient Advice Liaison Service (PALS) were necessary. We found leaflets on all wards visited informing people about how to make a complaint. Senior staff informed us they try to deal with complaints locally and had very few formal complaints.

Between June 2016 and June 2017, there was one complaint about services at the CCU. The complaint was in relation to medical care and poor communication.

Senior staff informed us they converted a shower room to a larger visitor’s room following feedback from patients about the small size of the previous visitor’s room.

Information provided by the trust indicates complaints were reviewed and signed off either by the Executive Medical Director or Chief Nurse with a covering letter from the Chief Executive. Complaints were linked to the Adverse Incident process as appropriate. We noted that all complaints we reviewed in the CCU had an outcome and a resolution date.

Is the service well-led?

Leadership

A clinical lead consultant and a matron led the critical care unit at the Princess Royal University Hospital (PRUH). They reported to the trust’s clinical director and head of nursing for the critical care service. A clinical lead nurse supported the head of nursing.

Staff told us they were supported by senior staff in critical care including the clinical lead and matron. Staff said the managers were visible and approachable.

During our inspection, we found that senior staff were visible on the wards and knew staff across the service.

Lines of accountability and responsibility on the units were clear and staff understood their roles and how to escalate problems. A band 7 nurse led each critical care team.
Doctors felt supported by the wider team as well as medical colleagues and told us they received good support from consultants.

The CCU participated in the trust’s “Commit to Care” initiative, an assessment and accreditation system based on a number of clinical outcomes. The unit scored 99% in the assessment for leadership.

**Vision and Strategy**

In April 2016, King’s College Hospital NHS Foundation Trust developed its “BEST” strategy (Best quality care; Excellent teaching and research; Skilled “can do” teams and Top productivity) where patients come first and receive the best care and services. The trust aimed to be an outstanding local hospital at the heart of the communities it served and a world-class centre for specialist clinical, teaching and research excellence. Staff were aware of the vision to provide the best care for patients.

During our last inspection in 2015, senior management told us they envisaged the service developing to increase its bed capacity. By the time of our recent inspection, the trust had approved a business case for a five-bedded extension to the CCU. Staff were aware of the department’s plans to extend the new critical care unit and could verbalise the plans. Staff were positive about developmental plans for the new unit and felt that it would allow more facilities for families. In addition, there was optimism that the new unit would alleviate the capacity issues in critical care.

**Culture**

All the staff we spoke with reported there was a positive culture within the unit. Staff felt they had opportunities to develop in their role and felt they worked within a very good team. Staff told us they were motivated because the trust was investing in their success through training and development.

Staff said they had good working relationships with other team members within the unit. We observed staff asking senior colleagues for guidance and advice being passed on in a patient and supportive manner.

Staff said the unit was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and followed the correct process.

Senior staff informed us qualified medical registrars were given the opportunity to progress to the position of consultants when the trust took over management of the PRUH. Medical staff confirmed they got educational supervision and study leave.

Between June 2016 and May 2017, the CCU reported a sickness rate of 3% for qualified nursing and midwifery staff. This is the same as the trust’s target sickness rate of 3%.

During the same period, the CCU reported an average sickness rate of 2.5% for medical staff. This is below the trust's target sickness rate of 3%.

**Governance, Risk Management and Quality Improvement**

Senior staff informed us the CCU was previously governed under the critical care, theatres, and diagnosis group at the PRUH. However, they were now governed under the trust wide critical care structure.

Senior staff held monthly risk and governance meetings to address several issues including red and amber serious incidents (Sis). We reviewed the minutes of the last two meetings and it
showed that the meetings were well attended by senior staff across the trust including medical leads, the head of nursing, clinical nurse lead, matrons from each critical care unit and the patient safety manager. Senior staff discussed the incidents on the unit and disseminated information to staff on the ward. Senior staff also discussed issues on the risk register, patient safety audits and compliance, infection control amongst others. We saw details of top risks and SIs highlighted in information provided on the notice board within the units. Staff also confirmed these incidents were discussed during staff meetings and they received emails regarding these.

The CCU maintained a risk register including concerns and assessments of potential risks on the unit. Mitigating plans were put in place to address those risks and senior staff routinely discussed risks at clinical governance meetings. There were seven risks on the CCU risk register.

Senior staff identified their main challenges as capacity, medical staffing and lack of technical support for equipment. These issues were on the risk register and there were controls in place to mitigate risks. They mitigated the risks to capacity with the services of iMobile staff providing support to patients on the ward. In addition, they used two beds in the recovery as an overflow area when they reach full capacity. They have now been able to obtain funding to increase bed capacity (additional five beds) by summer 2018.

By the time of our inspection, equipment including arterial blood gas analysers, ventilators and ultrasound machines had been replaced. Technicians had been recruited to rotate between critical care units at the PRU and at Denmark Hill.

The CCU relied on locum staff in order to mitigate the risk of insufficient medical staff. By September 2017, a business case to recruit addition medical staff had been approved. In addition, the CCU also secured approval for a fixed term locum consultant.

The risk register indicated that patients suitable for discharge to the ward were not always discharged at the earliest opportunity due to a lack of available beds within the hospital. In particular, tracheostomy patients were limited to specific beds they could be discharged to and this had a knock effect on the CCU. The CCU raised adverse incidents to highlight this and fed back information at daily bed meetings. The risk register highlighted there was an ongoing trust wide review of capacity needs. In the interim the iMobile team supported patients on the ward while admission areas were identified.

Public and Staff Engagement

Relatives’ questionnaires were being completed and boxes for these were in waiting rooms. Follow-up clinics were held with patients and their family and friends, which included a feedback element.

There were regular staff meetings and senior staff fed back relevant information to staff.

Notice boards within the critical care units and staff room had current information about risks, serious incidents, infection prevention and control, audits and training. Staff had access to a staff room on CCU. These had facilities for making beverages, a microwave, a fridge and storage.

Learning, continuous improvement and innovation

By the time of our inspection, a business case for a five-bedded extension to the CCU had been approved. Senior staff said the unit would open by summer next year.

Practice development nurses (PDNs) within the CCU worked with another London trust to deliver studies to CCU nurses.
There were plans to roll out electronic systems on the critical care unit so that patient notes would integrate with the current trust systems, national critical care systems and primary care.

In addition to its outreach services, the iMobile team also followed up critical care discharges and delivered critical care in ward beds. The team also delivered teachings and workshops to staff.

The CCU was actively involved in research in conjunction with the trust wide Anaesthetic, Critical, Emergency Medicine and Trauma (ACET) research team. We were provided with a list of the ongoing research activity in the CCU. We also saw information on notice boards within the unit in relation to ongoing research.

The CCU was awarded the ward of the month in May 2017 for working well under immense pressure and caring for patients in escalation areas. This was said to have been reflected in positive patient outcomes, and feedback and praise from patients and families.

The CCU had achieved three consecutive gold standard accreditations in the trust’s “commit to care” audits.

### Outpatients

#### Facts and data about this service

The outpatients department (outpatients) at the Princess Royal University Hospital (PRUH) is open 8.30am to 5pm, Monday to Friday.

Patients present to the department by appointment. Clinics are mostly held in outpatients, with some clinics held in other parts of the hospital.

Outpatient clinics are dispersed within the structure of the hospital. Many clinics are co-ordinated within the general outpatients and others are managed by clinical specialties.

Outpatient clinics are held for breast care; colorectal, dietetics, general surgery, gynaecology, haematology, obstetrics, and oncology as well as respiratory. The haematology and oncology day service was provided at the Chartwell Centre. (These services were part of the outpatients’ activity).

We visited a range of clinics including post-acute medicine, ophthalmology, gastroenterology surgical, rheumatology, cardiology, haematology, ear nose and throat, orthopaedic and the fracture clinic, the phlebotomy department and the therapies department. We also visited the Chartwell unit which specialised in the treatment of a range of cancers.

The trust had 1,430,961 first and follow up outpatient appointments between April 2016 and March 2017. The graph below represents how this compares to other trusts.
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, between April 2016 and March 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>King's College Hospital (Denmark Hill)</td>
<td>958,823</td>
</tr>
<tr>
<td>Princess Royal University Hospital</td>
<td>334,569</td>
</tr>
<tr>
<td>Kings College Dental Hospital</td>
<td>158,558</td>
</tr>
<tr>
<td>Kings @ Queen Mary's Hospital Sidcup</td>
<td>120,419</td>
</tr>
<tr>
<td>Kings @Beckenham Beacon</td>
<td>89,907</td>
</tr>
<tr>
<td>This Trust</td>
<td>1,782,377</td>
</tr>
<tr>
<td>England</td>
<td>104,564,225</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

The chart below shows the percentage breakdown of outpatient appointment types between 01 April 2016 and 31 March 2017 at King's College Hospital NHS Foundation Trust. The percentage of these appointments by type can be found in the chart below:
We visited the outpatients department over two days during our announced inspection. We looked at all areas of the department and we observed care and treatment. We looked at 10 sets of patient records. We spoke with 25 members of staff, including nurses, doctors, allied health professionals, managers, and support staff. We also spoke with 12 patients who were using the service at the time of our inspection. We reviewed information provided by the organisation prior to and during the inspection.

**Is the service safe?**

**Incidents**

The service had effective systems to ensure that incidents were reported and investigated appropriately. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.

Incidents were standard agenda items at monthly clinical governance meetings. The monthly meetings were attended by a staff representative from each service area. The minutes of these meetings demonstrated incidents were a standing agenda item and discussed at the meetings. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings.

Staff told us that learning from incidents was cascaded at team meetings. In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England between July 2016 and June 2017. The incident breakdown by type was as follows; two diagnostic incident including delay meeting SI criteria, including failure to act on test results, this was 67% of total incidents; one incident of treatment delay meeting SI criteria, this was 33% of total incidents.
Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Between July 2016 and June 2017, the trust reported no incidents classified as never events for outpatients.

The matron received safety alerts and was responsible for taking action to respond to relevant alerts. Staff told us safety alerts were discussed at clinical governance meetings. Staff told us completed actions would be reported to the Department of Health’s (DoH) central alerting system, (CAS).

Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents which had taken place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly in outpatients.

Providers were required to comply with the duty of candour regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a trust policy relating to duty of candour, which outlined actions to be taken when something went wrong. All staff with responsibilities to undertake root cause analysis investigations were trained in the duty of candour. All new medical staff received training in the duty as part of their induction training.

Staff and managers we spoke with were aware of and able to explain the duty of candour. The outpatient matron told us the department staff were honest with patients if clinics were running late and offered patients’ opportunities to rebook appointments. We viewed a duty of candour letter outpatients had sent to a patient. We found that the service had informed a patient about an incident in outpatients related to a diagnostic procedure. The letter sent out offered a sincere apology and informed the patient that work was in progress investigating the events concerning the diagnostic procedure.

**Cleanliness, infection control and hygiene**

Overall we found the outpatient department was compliant with the “Code of Practice on the prevention and control of infections and related guidance” issued by the Department of Health in 2010.
Cleaning schedules were in place and up to date with details of when areas were last cleaned and when cleaning was next due. However, we found gaps in the daily cleaning log in consulting room 8 for September 2017.

Policies and procedures for the prevention and control of infection were in place and staff adhered to “bare below the elbow” guidelines. Personal protective equipment (PPE) and hand gel was readily available in all clinical areas and we observed staff using it.

Patients were cared for in a visibly clean, hygienic environment. All of the clinical areas we visited were clean and well maintained. We inspected toilets and sluices and found them to be clean.

Equipment had an ‘I am clean’ sticker applied when it was cleaned. Clinical waste was managed safely and bins for sharp items were correctly assembled and labelled. Overall, there was safe storage and disposal of sharps. However, we saw a sharps bin in the clean utility that did not have a date recorded and where the lid was not fully closed.

The trust conducted annual infection control audits of the outpatients department. We viewed the findings of the audit and action plan in response to the audit dated March 2017. We saw that actions identified in the action plan had been implemented, including the replacement of hand hygiene posters across the outpatients department.

We observed cleaning taking place and saw cleaning schedules. Supervisors checked completion and the matron told us they did ‘walk aro..."regularly to monitor cleanliness.

Hand hygiene audit results were displayed on a noticeboard in the outpatients department dated 28 August 2017. These recorded that five staff had been observed before patient contact, before aseptic tasks, during fluid exposure, and after patient contact. The results of the audit were that staff had achieved 100% compliance with hand hygiene practice. Senior nursing staff said that outpatients department consistently achieved a compliance rate of 100%.

Hand hygiene stations were readily available, appropriately stocked and observed to be in regular use.

Alcohol gels were available outside of all clinical rooms in outpatients with signage asking staff and patients to gel their hands prior to entering. Alcohol gels were also available in the outpatients’ reception.

There were notices in the main reception area reminding patients not to attend their appointment if they were suffering from vomiting and diarrhoea, and to contact the department to rearrange their appointment once they were free of vomiting and diarrhoea symptoms or if their symptoms persisted to contact their GP.

Environment and equipment

The outpatients department had an outpatient’s entrance, which led to the main outpatients’ reception. There were two separate corridors leading from the main reception to separate consultation rooms and treatment rooms. One of the corridors also led to the fracture clinic plaster room.

Medical device inventories were kept up to date by the trust’s estates team. The outpatients department received a reminder via email when equipment servicing was due. Safety testing for equipment was in use across outpatients. The equipment we reviewed had stickers attached; these indicated when electrical testing had been completed. Equipment servicing stickers we viewed were in date.
There was a power cut leading to a loss of electrical lighting during our visit in the outpatients department. The corridors were immediately lit by emergency lighting. The power cut lasted for less than two and a half minutes, when generators restored the power and lights. Staff told us it was the first time there had been a loss of lighting in the outpatients department and power cuts were not a common occurrence. Loss of lighting was covered in the business continuity plan.

Personal protective equipment (PPE), such as gloves and aprons were available to staff across outpatients. We saw staff using PPE appropriately.

We found the resuscitation trolleys located throughout the departments were locked and medicines and stock inside the trolleys were appropriate, stock was sealed and had been checked daily. Staff reported that these checks were high priority. Defibrillators were tested on a daily basis. Oxygen cylinders we looked at were all in date.

Some staff told us the age of some parts of the hospital could present a challenge in terms of equipment storage. However, we did not see in any of the departments we visited equipment stored where it might pose a risk to the public or unsupervised equipment that could have been tampered with.

**Medicines**

Prescription pads (FP10) were not stored securely and their appropriate use was not monitored. We saw prescription pads stored in clinical rooms that were not locked. We saw unsecured prescription pads on desks, window sills, and in one room prescriptions were stored under a telephone. We drew this to the attention of the chief nurse, who took immediate action to ensure prescription pads were stored securely.

We reviewed the ‘Medicines Management Policy, version 5’, ratified on 31 August 2017. We found there was a section on prescribing in outpatient, (s5.5.1.2). The policy clearly detailed the trust’s policy on the storage of medicines. However, the policy did not include a section on the storage of prescription pads (FP10) or detail whose responsibility it was to ensure secure storage of prescription pads.

Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the department.

All outpatient clinic areas had registered nurses on duty during clinic opening hours and they signed for the medication storage keys.

Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open. All fridge records for September 2017 were within the required range and up to date.

Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support about medication as part of the patient’s consultation.

The trust was rolling out electronic prescribing commencing in October 2017. However, at the time of inspection there was no date confirmed for the introduction of electronic prescribing in outpatients.

**Records**
During our previous inspections in April and September 2015 staff (both clinical and non-clinical) told us there had been a significant problem with obtaining medical records. Clinicians had told us in April 2015 that there had been extensive use of temporary medical records for some patients. During our inspection in September 2015 we reported that 21% of patients were seen without their medical records. However, when we visited in 2017 staff reported that these issues had been resolved and patients that did not have their medical records available for clinics was a rare occurrence.

We viewed a records audit dated March to August 2017 and found 97% of records were available for clinics during this period.

We found large amounts of patients’ paper based notes stored in corridors outside clinical rooms in the outpatients department. However, staff at the outpatients department told us storing notes was an issue due to a lack of space. The matron told us the outpatients department had been built as a paperless building, and the footprint of the building did not facilitate storage of paper based notes. The notes we saw in corridors were not secure. The notes were stored in boxes, and staff had covered the notes with tissue paper, but the notes were still visible and accessible to anyone entering the corridors. We noted staff were not always present in the corridors, as they were busy in clinics. This meant unauthorised people could gain access to patient notes and patients personal and health information.

The hospital’s risk register recorded the risk of paper based notes stored in corridors. In mitigation the register recorded that a member of staff should always be present in the corridor.

We saw numerous occasions when staff were busy and the corridor was unsupervised. The register also recorded paper based notes storage would be resolved when the trust moved to electronic records. The roll out of electronic records was scheduled for October 2017. However, staff in the outpatients department told us this was a staggered process and they were not aware of exactly when the new records system would be rolled out in outpatients.

We observed a room in the outpatients department where notes were stored following clinics for return to the medical records department. The room was accessible from the outpatient waiting room. The door to the room had signage saying access was for staff only, but the room was unlocked and we gained entry. Unauthorised people could gain access to patient’s notes from the waiting room.

There was a patient electronic management system (PIMS), which provided staff with access to letters, reports, imaging and test results. However, most patient records were paper based, including risk assessments. Staff told us a new electronic record system (ERS) was being rolled out in October 2017.

We viewed seven patients care records. Patient discharge summaries and referral letters were in their care records, together with risk assessments that included a record of patient’s allergies, activities of daily living (ADL), whether they were at risk of venous thromboembolism (VTE), and whether they had an assessment of mental capacity.

Information governance was part of the trust’s mandatory training. Staff told us they had received information governance training. The staff training system recorded that 95% of outpatient staff had completed mandatory training.

The trust’s website carried information on people’s rights under the Freedom of Information Act 2000. In relation to patients’ rights to access their medical records.

Safeguarding
Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to.

Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Staff we spoke with were able to describe the different categories of abuse.

Bank staff received the same safeguarding training as permanent staff and ad hoc training was also provided by safeguarding team as and when required.

We saw a safeguarding flowchart displayed in the outpatient reception area; this detailed the pathway for escalation of safeguarding concerns.

Staff were trained to an appropriate level in adults and children’s safeguarding. The matron told us they were trained to level 4 in children’s safeguarding and nursing staff were trained to level 3. Health care assistants (HCA) were trained to level 2 in children’s and adults safeguarding.

The trust set a target of 80% for completion of safeguarding training. A breakdown of compliance for safeguarding courses between June 2016 and May 2017 for all medical/dental and nursing staff in PRUH is shown below:
Medical staff were underperforming against the trusts 80% target with an overall completion rate of 46%. Nursing staff were exceeding the target at 90%. However, we did not receive an explanation of why there was a 0% rate for safeguarding adults’ level 1; this has been disregarded for these percentages. It is likely that this had been recorded incorrectly.

(Source: Routine Provider Information Request (RPIR))

Mandatory training

The trust had recently introduced a new mandatory training portal. Managers told us the system was more user friendly. However, the system had been rolled out two weeks prior to the inspection and managers said there were some glitches, including all the mandatory training courses staff had completed not showing on the system. Staff said they had to show copies of their training certificates to the IT department and have this training added. This was work in progress. Staff and their line manager received email reminders when mandatory training was due.

Training for staff in basic life support (BLS) was mandatory in the outpatients department. However, managers said BLS training was at the trust’s Denmark Hill site, and this meant releasing staff for a day to complete the training. Hence, only one member at a time could be released to do the training. Staff said they had asked for BLS training to be offered on-site at PRUH to enable staff to complete this in a block, but this had not been implemented.

The trust set a target of 80% for completion of mandatory training. A breakdown of compliance for mandatory courses between June 2016 and May 2017 for all medical/dental and nursing staff in PRUH is shown below:
Medical staff were performing below the trust’s mandatory training completion target of 80%, with a completion rate of 50%. The nursing staff were performing above the trust’s target completion rate, with a completion rate of 84%.

(Source: Routine Provider Information Request (RPIR))

However, information submitted by the trust dated August 2017 showed an improvement on these figures. We found most mandatory training had a completion rate of 100%, with the exception of: fire training (89%); infection control two yearly update session (83%); information governance (72%); resuscitation (52%); slips, trips, falls (88%); venous-thromboembolism (56%).

Assessing and responding to patient risk
Patient referrals were immediately logged onto the patient electronic management system (PIMS), which identified patients who were at risk of deteriorating.

There were arrangements in place to deal with foreseeable medical emergencies. Senior managers told us that escalation of risk was normally done from a ward level. Ward managers discussed risk with their line managers who escalated to the service director, then onto the risk register if required.

The trust had a policy for managing deteriorating patients. However, staff told us there was no specific policy for the outpatients department in managing a deteriorating patient.

Staff used the national early warning score (NEWS). This is an observation chart that determines the degree of illness in a patient using six observations of patient’s vital signs, for example, blood pressure, pulse, respirations. Staff were aware of the escalation protocol for recognition and response to a patient whose condition was deteriorating.

Staff we spoke with were able to describe the procedure if a patient became unwell in their department including calling the medical emergency team.

All staff working in the outpatient department had completed ‘basic life support’ training. In addition, nursing and medical staff all received immediate life support training (ILS), and could act as first responders to patients in cardiac arrest until the medical emergency team arrived.

During a short power cut in the department we saw a member of staff in the phlebotomy clinic stop taking a patient's blood sample. We saw the member of staff explain to the patient that they would continue when the power was restored. The member of staff continued with the blood sample when power was restored, thereby minimising risks to the patient.

The outpatient reception area had posters raising awareness of falls prevention and asked patients to ask staff for assistance if they were concerned about their risk of falls.

**Nursing staffing**

Nursing services in the outpatient department were provided by the outpatient nurses and clinical nurse specialists (CNS). For example, CNS for cardiothoracic, cardiology, neurology, gynaecology, and respiratory.

Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. However, this was often supplemented by bank and agency staff or staff flexing across the service. The matron told us outpatients could not always provide all the nursing staff that medical staff requested. This meant some ad hoc clinics could not be provided.

We viewed the staffing spreadsheet for the post-acute group for September 2017 and found the division had across all nursing bands 214 whole time equivalent (WTE) nursing staff. The actual number of nursing staff posts that were in post was 192. This meant the division had 22 WTE nursing vacancies. (It should be noted that these figures relate to the division and not just outpatients).

A safe staffing dashboard was displayed in the outpatients department. This showed details of the required levels of staffing, and actual levels present on each day. Staffing levels were adequate, as was the required skill mix at the time of our visit. The matron demonstrated an online acuity tool which was used to assess the required staffing levels for each day. The matron explained that staffing was assessed daily, dependent upon the nursing requirements for each clinic.
There was a bank for nursing staff so the hospital had cover for staff sickness and holidays. Bank staff had an induction and mandatory training was provided. Many of the bank staff had worked at the hospital before and were familiar with the trust’s processes. The matron told us outpatients could also request staff from Orpington and Beckenham outpatients departments if the PRUH was short of staff.

The matron and staff in the phlebotomy clinic told us sometimes the clinic could not have all the phlebotomy chairs in the clinic operating due to a lack of staff; and this had an impact on waiting times for patients.

Senior nursing staff told us nursing recruitment had been outsourced to a private company and this had led to delays in getting staff on-board. For example, we were told two band 2 HCA posts had been offered in April 2017 and the staff had not received start dates in September 2017. Senior nursing staff said they were concerned that delays would lead to the new recruits finding other jobs.

Kings College NHS Trust reported their staffing numbers for the period June 2016 and May 2017 at a trust wide level. These numbers fall below the trusts target for a WTE staffing level of 4508.99 within the qualified nursing and midwifery arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>3847.99</td>
<td>4170</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Between June 2016 and May 2017, the trust reported a vacancy rate of 14% PRUH for qualified nursing and midwifery staff. This was higher than the target vacancy rate of 8%. There was some variation in the rate over a 12 month period, peaking at 16% in March/April 2017 and dipping to 11% in November/December 2016.

Between June 2016 and May 2017, the trust reported an annual turnover rate of 15.3% with an average monthly turnover rate of 1.2% at the PRUH for qualified nursing and midwifery staff. This was lower than the trusts target annual turnover rate of 20%.

Between June 2016 and May 2017 the trust reported an average monthly sickness rate of 3.3% at PRUH for qualified nursing and midwifery staff. This was higher than the trust’s target sickness rate of 3%.

**Medical staffing**

Overall, medical led clinics had a sufficient number of medical staff to support outpatient clinics. However, medical staff in cardiology said there was a vacant consultant post that had an impact on the number of clinics that could be offered. The post had been recruited to and the new consultant was due to commence work in October 2017.

Medical cover for clinics was arranged within the divisions, which agreed the numbers of clinics and patient appointments.

Staff told us medical staff observed the trust’s policy of medical staff giving a minimum of six weeks’ notice of any planned absences, for example, holidays or training.
The trust reported their staffing numbers below for the period June 2016 to May 2017. These numbers fall below the trust’s target for a WTE staffing level of 2183.09 within the medical staff arena across the trust.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post as of May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings College Trust</td>
<td>1885.88</td>
<td>2090</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR))

Between June 2016 and May 2017, the trust reported a vacancy rate of 20% in medical and dental staff at PRUH. This exceeded the trust’s target vacancy rate of 8%;

Between June 2016 and May 2017, the trust reported an annual turnover rate of 40% and a monthly average rate of 3.4% in medical and dental staff at PRUH. This exceeded the trusts target turnover rate of 20%. There was a significant spike in turnover in August 2016, where the rate was recorded at 19.8% for the month.

Between June 2016 and May 2017, the trust reported an average monthly sickness rate of 2.5% at PRUH for medical and dental staff. This was lower than the trust’s target sickness rate of 3%.

Major incident awareness and training

Staff were aware of the trust’s business continuity policy. Senior staff understood their roles and responsibilities in the event of an interruption to normal business. For example, in the event of flood or chemical spills.

The trust had a major incident policy and staff told us there were staff allocated to assist in the event of a major incident.

Staff had worked with the site management team to assess current risks. We were told staff were encouraged to attend major incident training

Is the service effective?

Evidence-based care and treatment

Clinics were usually well organised and delivered effective assessment and treatment. Staff delivered evidence based care and followed National Institute for Health and Clinical Excellence (NICE) guidelines where relevant. Staff attended regular clinical team meetings where they learnt about new and updated guidance. For example, NICE guidance for gastroenterology.

Staff at the hospital had been involved in developing best practice guidance. For example, a clinical nurse specialist (CNS) for Parkinson’s disease had been involved in writing guidelines for junior doctors, and had been involved in producing guidelines with the Parkinson’s regional peer group.

Staff in outpatients demonstrated how they could access trust policies and guidelines on the trust intranet.

Cardiac rehabilitation in the cardiology clinic was an evidenced-based practice using secondary prevention measures and modification of lifestyle behaviours. The service also provided drug intervention to minimise the risk of patients experiencing further cardiac events and to improve symptoms in patients suffering with chronic heart disease.
Managers told us the introduction of a new IT system had provided the trust with the opportunity to review all patient pathways. Work was in progress with cross site groups that were looking at improvements to patient outcomes, and this work would feedback to trust steering groups.

**Pain relief**

Staff were able access appropriate pain relief for patients within outpatients’ clinics. Patient’s pain was assessed and monitored. Staff in outpatients could give patients paracetamol if they experienced pain, but if patients needed other analgesia these would be prescribed by a medical practitioner upon request.

There was a pain clinic for patients experiencing pain. Patient’s pain was monitored and reviewed, and changes made in response to patient need or pain relief not having the desired effect for the patient.

Records confirmed that patients’ pain needs were assessed before undertaking any tests in the majority of cases.

**Patient outcomes**

We viewed the surgery audit schedule for 2017 and saw this provided a framework of local and national audits to measure and ensure practice was patient-focused.

The outpatients department were involved in a range of national audits. For example, outpatients had been involved in the National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis published in June 2017. The audit found the trust were slightly below the national and London average for degree of health recovery outcomes. For example, the proportion of patients achieving a minimum clinically important difference (MCID) for rheumatoid arthritis impact of disease (RAID) score, the trust scored 57% compared to a national average of 60%.

The outpatient department used a ‘heat map’ to benchmark services. However, the service did not have dashboard or balanced scorecard to monitor patient outcomes. Between 01 April 2016 and 31 March 2017 the follow-up to new rate for the Princess Royal University Hospital was better than the England average.

*Follow-up to new rate, King's College Hospital NHS Foundation Trust.*
New staff received a local and corporate induction. For example, a registered nurse told us they had been employed in July 2017 and had received an induction and been allocated a ‘buddy’ to support them in the first six months of employment. The buddy was an experienced member of staff who could support them with understanding the departments systems and processes.

Staff received annual appraisals. All the staff we spoke with said they had received an appraisal from their line manager in the previous 12 months. Data received from the trust for the period between June 2016 and May 2017, 42% of overall staff at PRUH had received an appraisal compared to a trust target of 90%. However, figures received from the trust in September 2017 indicated that 85% of staff had received an appraisal.

Staff told us appraisal information may not have been up to date at the time of inspection due to a new electronic record system being introduced and data not being transferred across systems. Work was in progress to ensure staff appraisals were recorded on the new recording system.

The matron of outpatients had not received an annual appraisal for over two years. They told us the head of nursing was responsible for their appraisal, but said they recognised the head of nursing was really busy. However, this meant the matron was not having their professional development regularly reviewed and any areas for improvement identified.

Staff received regular supervision and team meetings. We viewed the minutes of team meetings during the inspection and staff told us they received regular supervision.

The outpatients department provided clinical support for nursing staff: This included: clinical nurse facilitators, clinical peers, and buddies.

We spoke with health care assistants (HCA) and observed the care they were giving in clinical areas. Some HCA’s were trained for specific tasks, for example taking blood or taking physiological measurements. HCA’s told us they received direct supervision from registered nurses. HCA’s told us their electronic training records recorded any specialist training they had undertaken and they received emails to notify them when training updates were due. However, due to issues with a new electronic system being introduced we were unable to verify this.
Competency assessments were in place for outpatients and induction processes were in place for new staff.

Some staff told us they were able to obtain further relevant qualifications. Staff in oncology said there were plenty of development opportunities, and staff were encouraged to broaden their skills base.

There were a range of in-house training opportunities. However, health care assistant (HCA) staff in outpatients told us the funding for HCA staff completing validated training had been withdrawn in September 2017, and they had not been informed of a new date to begin studying for qualifications.

Staff told us they were supported with revalidation of their registration with their professional regulatory bodies. For example, we saw the registrations of staff with nursing and midwifery council (NMC).

Both senior medical staff and senior nursing staff were complimentary about the nursing and support staff in outpatients. For example, a member of the medical staff said, “They are very good at making do. Clinics work because of the staff.”

Staff told us they had mental health training as an aspect of vulnerable adults training. Staff told us the actions they would take to support a person with mental health needs or a person who was experiencing a psychotic episode. Staff were aware of how to contact the community mental health team (CMHT). However, staff said they had not received any specific mental health training.

There were clinical governance days where staff could look at practice issues and review case histories as an aspect of learning.

A clinical nurse specialist (CNS) in Parkinson’s disease had been supported to attend regional conferences and meetings to keep up to date with current and emerging practice initiatives.

**Multidisciplinary working**

There were regular multidisciplinary team (MDT) meetings in outpatient specialisms. However, a few staff told us there was no MDT meeting in outpatients that included and crossed specialisms. This meant there was limited opportunity for specialisms to exchange ideas and share learning.

The Parkinson’s disease CNS had weekly meetings with the consultant and community nursing team. The CNS also attended MDT meeting in neurology and physiotherapy.

Staff in the outpatients appointment call centre, told us they worked well with the outpatients reception staff.

Therapists including OT and physiotherapists were part of the outpatients department MDT. The cardiac rehabilitation clinic provided patients with MDT assessments involving nursing and physiotherapy assessment, cardiac risk factors identification and modification, education, support, counselling and prescribed exercise, as well as medical evaluation.

Staff at the oncology and chemotherapy day clinic worked closely with Macmillan nurses to ensure continuity of care for patients in the community.

Patient information was shared with GP’s following hospital attendance to ensure continuity of care.

**Seven-day services**
Outpatient clinics operated from 8.30am to 5.30pm Monday to Friday. There were no regular weekend clinic appointments in the outpatients department. Staff said they had reviewed offering weekend clinics, but there had been a lack of demand from patients for weekend clinics.

Health promotion
Staff we spoke with told us there was a lot of focus in the outpatients department on how services could meet the needs of patients with a learning disability or patients with dementia. For example, staff at the outpatients said letters could be provided in ‘easy read’ formats or large print.

Staff said if they were aware of a vulnerable adult attending an appointment they would provide assistance. There was a learning disability notice in the outpatient reception in easy read format explaining how people with a learning disability could access the local authority learning disability team. Reception staff told us they would be aware of anyone attending an appointment with a learning disability. Staff said they would be made aware that more time was needed to undertake the examination and would not interrupt.

The main reception had a falls prevention poster, this advised patients who were frail to ask for assistance from staff.

There was a wide range of printed information available to patients and their families and carers, including a range of information leaflets and literature for patients to read about a variety of conditions and support services. For example, patient information on: venous thromboembolism (VTE), information on smoking cessation, and information on mental health and wellbeing, and substance misuse.

Access to information
Staff across clinics we visited demonstrated how they could access the test results all the information needed to deliver effective care and treatment in a timely way from the patient electronic management system (PIMS). Diagnostic results were recorded on PIMS, giving staff immediate and up to date access to patients’ imaging records.

The outpatients department had a preparation room. This was a room where patient information was prepared for clinics. Staff told us there had been improvements in the information that was available for clinics. Staff received up dated patient’s clinical information in the preparation room in readiness for clinics.

The service was rolling out a new electronic records system commencing in October 2017, with the intention of improving the accessibility of patient information. However, outpatients’ staff told us they were not aware of a specific date for the roll out in outpatients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Overall, the service complied with the Mental Capacity Act 2005 (MCA), Code of Practice 2007.

The trust had an up-to-date policy and procedure relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination, and set out how that consent was to be obtained and recorded. For example, staff at the fracture clinic were aware of Gillick competence, this is a decision based on whether a child is able to consent to their own care and treatment without the need for parental knowledge or permission.
We saw from patients’ records and discussion with patients and staff that consent had been obtained before treatment was given in all the clinics we visited. Clinical nurse specialists were able to describe the process of assessing capacity when obtaining consent.

The outpatient staff room had a MCA decision flowchart on a whiteboard in the staff room. This provided staff with guidance on decision making for patients who may not have the capacity to make decisions. Staff were encouraged to document best interest and capacity decisions.

The safeguarding team delivered training on mental capacity, deprivation of liberty safeguards (DoLS), and prevent, (this is a strategy to identify people at risk of being drawn into terrorism).

There was also information on these topics available to staff on the trust intranet. The trust reported that between June 2016 and May 2017, MCA training had been completed by 75% of eligible staff at the time of our visit; this was below the trust target of 80%. However, there was time to complete training before the end of the financial year.

Deprivation of liberty training data was not provided and was not available at the time of this report.

Is the service caring?

Compassionate care

Staff were caring and compassionate. During our inspection we saw and heard many examples of staff treating patients with compassion, dignity and respect. For example, a patient in a wheelchair told us staff at the fracture clinic had come from the clinic to assist them in manoeuvring the wheelchair into the waiting area of the fracture clinic.

Patients were positive about the care they had received. Doctors, nurses and healthcare assistants spoke to patients in a dignified way. We observed staff introducing themselves by name and explaining their roles to patients. Patients also confirmed that staff introduced themselves and explained their roles.

There was a royal college of nursing (RCN) ‘definition of dignity’ poster displayed in the main reception. One member of staff told us it acted as a reminder of how to behave towards patients and colleagues.

The outpatients’ staff room had a whiteboard with patient feedback. For example, one feedback was labelled as negative and read that the phlebotomy department had put a note on the ticket machine saying the clinic was closing at 3.45. There were also ‘hint and tips’ notes on the whiteboard for staff on improving patient experience. The matron told us the whiteboard was an informal method in assisting staff to identify shortfalls and improve patients’ experiences of the service.

The ‘heat map’ dashboard for patient experience found that between September 2016 and August 2017. We found 97% of patients had responded that they were treated with dignity and respect, this was better than the hospital target of 94%. In the same survey 97% of patients said they had been treated with kindness and compassion by both the reception and the clinical staff. This was better than the hospital target of 94%.

We observed that staff asked patients waiting in the main outpatients’ reception how they were feeling and asked whether they needed anything. The reception area was at an appropriated
distance from the seating area and meant patients could not be overheard when speaking with
reception. Staff also told us patients could speak with staff privately in a room upon request.
However, the plaster room in the fracture clinic did not protect people’s privacy and dignity.

This was due to a partition wall that did not reach the ceiling and conversations between patients
and staff being overheard. Staff had placed a screen across a gap between the partition wall and
supporting wall to ensure patients in the waiting area could not see patients having treatment in
the clinic.

We saw examples of compliments that outpatients had received from patients about the kindness
and compassion displayed by staff. Cards that staff had been given by patients and their carers
were displayed on noticeboards in the staff room.

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

Patients and relatives told us they felt informed about the processes in the outpatients department
and received regular updates on their care and treatment.

Overall, patients and relatives told us they were involved in decisions about their care and
treatment. A patient told us, “They explain things to you. They ask before they do anything.”
We saw nursing staff seeking consent before carrying out tasks. We also saw the matron provide
directions to a patient in a corridor who was looking for a clinic.

Patients told us they received instructions with their appointment letters and were given written
information as required.

We saw reception staff in outpatients being friendly and informative when patients arrived for their
appointments. A patient told us, “They are ever so good. We will only come to Princess Royal
now.”

The ‘heat map’ dashboard for patient experience found that between September 2016 and August
2017 found 89% of patients said they had been involved in their care. This was better than the
hospital’s benchmark of 85%.

There was information in the outpatients’ reception area on chaperones. This informed patients
that a chaperone was available to accompany them during their appointment upon request.

**Emotional support**

Staff we spoke with understood their role in providing emotional support to patients and their families.
Health care assistants (HCA) in the phlebotomy clinic told us they had received training in
breaking bad news and supporting patients and families that had received bad news.

Staff told us the hospital had a multi-faith chaplaincy that could provide listening and emotional
support if requested to all patients.

The hospital had a multi-faith chapel/prayer room that was open 24 hours a day. Staff told us
people of all faiths could use the room and all were welcome to the regular services. These were
Christian services seven days a week, and Muslim Jummah prayers on Friday from 1.00pm until
2.00pm.

The hospital’s psychological service provided psychological and psychiatric consultation,
assessment and therapeutic intervention to patients and their families and carers where required.
Is the service responsive?

Service planning and delivery to meet the needs of local people

We were told the director of delivery and improvement had a working group for the transformation of outpatient services across the trust.

As an aspect of the service redesign work was in progress on introducing an electronic estates management system. This would provide real time monitoring of the availability of clinical rooms in the departments. Staff told us this had been rolled out at the trust’s Denmark Hill site, but there had not been the resources at PRUH to roll the system out at the same time.

The trust had a call centre based at PRUH. The service delivery manager told us they were involved in a ‘yellow belt’ transformation project, which was looking at the digitalisation of patient appointment bookings. However, there was limited funding available for the project.

As part of the outpatients transformation agenda work was in progress in outpatients to conduct a demand and capacity analysis to develop a model whereby the hospital could assess and effectively manage the demands on the department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.

The service manager for outpatients told us there was a scarcity of clinical rooms for clinics to expand.

Clinics could apply for ad hoc clinics by submitting a request to the outpatients’ matron. The matron would look at the availability of rooms and nursing support to decide whether there was capacity available to offer the clinic.

Managers told us there were a variety of models for the outpatients department. This included a traditional outpatients model, nurse led clinics and rapid access services.

Outpatient department appointments offered a mixture of nurse and medical led clinics. General outpatient nursing services included a variety of tasks and tests, which included: dressings; injections; phlebotomy, blood tests; urine tests; body mass index (BMI) measurements, blood pressure measurements; and administration of medicines.

Seating in the outpatients main reception area was arranged by clinic. Each area had signage with the name of the consultant leading the clinic. This meant patients would be seated in the appropriate waiting area and able to hear staff when they were called for their clinical appointment.

Referrals were sent via an electronic records system (ERS). Staff told us from 1 October 2017 all Bromley, Lambeth, Southwark, and Bexley care commissioning groups (CCG) would convert to ERS referrals. There was a plan in place that all GP referrals to the trust would be via the ERS by December 2018. However, staff said GP referrals in PRUH were already electronic. The outpatients’ service manager told us they liaised closely with the CCGs and were part of a steering group for the roll out of the ERS.

The service manager for outpatients told us work was in progress to train consultants on how to review referrals online.

The fracture clinic had been relocated as a result of the ambulatory care unit being relocated to the fracture clinic’s former location at PRUH. Staff told us they were plastering up to 700 patients a month. However, the plaster room in the fracture clinic was small and cramped. There was a partition wall that did not provide privacy for patients. The clinic did not have a store room and had filing cabinets to store equipment and stock. Staff told us beds had to be navigated around walls in
the small corridor to the plaster room. Staff told us the estates department had put rubber on the wall edges, due to beds and wheelchairs catching the walls. The plaster saw, which was used for removing plaster, could be heard in the waiting area, and a child visiting the service told us this had disturbed them; another patient told us, “It’s a bit alarming.” The décor in the plaster room was not child friendly.

We viewed the hospital’s risk register and saw this recorded that a business case had been submitted to improve facilities at the fracture clinic, but the business case had been rejected. However, there was no plan in place to improve the environment in the fracture clinic, although the register recorded that virtual clinics were being given consideration. However, staff told us there had been no decision in regards to this.

There was an electronic screen in the outpatients’ main waiting area which was for patients to leave feedback. However, staff told us the screen had, “Never worked”, and described the screen as an, “Ornament.”

**Access and flow**

The trust had 1,430,961 first and follow up outpatient appointments between 01 April 2016 and 31 March 2017.

Between 1 July 2016 and 30 June 2017 the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. The figures for June 2017, showed 81.4% of this group of patients were treated within 18 weeks versus the England average of 90.4%.correlating with the spike in the did not attend rate.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, King's College Hospital NHS Foundation Trust.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Five specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>96.1%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>94.2%</td>
<td>92.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>90.2%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>88.5%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>83.9%</td>
<td>80.6%</td>
</tr>
</tbody>
</table>

14 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).
### Referral to treatment (percentage within 18 weeks) – incomplete pathways

Between 1 July 2016 and 30 June 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance.

As the graph below shows, the trust underperformed against the England average throughout the entire reporting period. A gradual slump begins in August 2016 and the decline continues across the rest of the reporting period.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, King’s College Hospital NHS Foundation Trust.**

(Source: NHS England)

### Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>90.0%</td>
<td>88.2%</td>
</tr>
</tbody>
</table>

13 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>73%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Specialty</td>
<td>1st Quarter</td>
<td>2nd Quarter</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>91.2%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>78.6%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>86.3%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>90.7%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Urology</td>
<td>77.1%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Other</td>
<td>80.2%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>81.1%</td>
<td>92.4%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>69.2%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>81.4%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>85.1%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>76.6%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>72.7%</td>
<td>89.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

We discussed incomplete pathways with the service manager they told us there was a challenge across the trust with incomplete pathways due to issues with clinic capacity. The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral for the first two quarters. A dip below the average was then seen, with the trust recovering in quarter four. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), King's College Hospital NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), King's College Hospital NHS Foundation Trust

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, King’s College Hospital NHS Foundation Trust

PRUH had a two week wait office which specialised in tracking cancer patients.

The service manager for outpatients told us there was a weekly RTT meeting in the board room with the deputy managing director. The service manager told us each patient on a waiting list was reviewed. However, staff we spoke with across outpatients were unable to locate RTT or DNA information on their computers or explain either the RTT or DNA rates of the trust or the hospital. Staff told us this information was gathered by the Business Intelligence Unit (BIU), but some managers across outpatient services were not aware if the BIU shared the information.

The service manager told us RTT and DNA rates were affected by medical staff shortages. This meant some clinics could not expand or offer extra clinics.

Between April 2016 and March 2017 the ‘did not attend’ rate for Princess Royal University Hospital was similar to the England average, with a spiked decline in performance in June 2016.

The chart below shows the ‘did not attend’ rate over time.
The service manager told us they had introduced an initiative whereby patients would not be discharged following their first missed appointment. Cancellations did not count towards the DNA rate figures. Patients who cancelled two appointments would be referred back to their GP. GP’s could use the outpatients’ department ERS online appointments. Consultants triaged referrals and secretaries booked appointments. Staff told us patients could rearrange appointments if the allocated time wasn’t convenient, once they had received an appointment letter.

Staff said same day appointments could be arranged for urgent referrals as departments scheduled urgent appointments daily.

The outpatients department had introduced tracking lists for patients to monitor individual patients’ access to assessment, diagnosis and treatment. The patients waiting time and time of their appointment were being monitored as an aspect of the trust’s demand and capacity review. However, middle managers were unaware of the data that was available, as they said this was not disseminated by the BIU.

The trust had a call centre based in PRUH. The answer rate for the call centre was 90% of calls answered within one minute. The call centre had a digital directory of services (DOS) screen display. These are pathways that provide the call handler with real time information about services available to support a particular patient and ensure they are directed to the appropriate service. The service delivery manager told us they could monitor all calls in real time.

The call centre had introduced a telephone queuing system, which informed patients of where they were in a telephone queue and gave them the option of calling back when lines were less busy.

The ‘heat map’ dashboard for patient experience found that between September 2016 and August 2017 an average of 68% of patients had a positive experience of booking an appointment. This was less than the hospital’s benchmark of 80%.

Patients could receive text reminders to their mobile phones for outpatients’ appointments. Patients would be asked if they were attending their appointment, if they were unable to attend they were asked to inform the outpatients department, so that the appointment could be rearranged and the original appointment time offered to another patient.
If clinic appointments in outpatients were delayed staff told us they would inform patients verbally of waiting times. We saw staff verbally informing patients of a delay in a clinic due to a consultant being delayed in traffic. There were notices informing patients of waiting times for clinics. There was also a visual display screen in the reception area alerting patients to delays in clinics. For example, we saw the screen informing patients of a 30 minute delay to the ear, nose and throat (ENT) clinic.

The ‘heat map’ dashboard for patient experience found that between September 2016 and August 2017 an average of 47% of patients who responded said they had been seen on time. This was worse than the trust benchmark of 70%.

We saw long waits in the phlebotomy clinic. For example, at 1.40pm on 5 September 2017 patients were informed that there was a 45 minute wait for blood tests. We counted 31 patients in the phlebotomy waiting area. We also saw 40 minute waits on the same day in the fracture clinic.

The ‘heat map’ dashboard for patient experience found that between September 2016 and August 2017 found that an average of 24% of patients said they had been given information on waiting times. This was worse than the trust benchmark of 60%.

Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge.

GP’s could use the outpatients’ department ERS online appointments system, e-referrals, or paper based referrals.

Consultants triaged referrals and secretaries booked appointments. Staff told us patients could rearrange appointments if the allocated time wasn’t convenient, once they had received an appointment letter.

Staff said same day appointments could be arranged for urgent referrals as departments scheduled urgent appointments daily.

The outpatients department had introduced patient tracking lists (PTL) to monitor individual patient’s access to assessment, diagnosis and treatment. Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge.

**Meeting people's individual needs**

The outpatients department had access to a range of support to meet their individual needs including: physiotherapy, speech and language therapists for voice, ear nose and throat (ENT) and respiratory disorders.

Patients with hearing loss had access to British sign language (BSL) support.

The phlebotomy clinic fast tracked patients with complex needs if these were known to the service, for example sickle cell, HIV, or pregnant women, although there was no flagging system. Staff said they were reliant on patients informing them of any individual needs.

There was provision for bariatric patients in the form of a bariatric treatment table in the treatment room.

Staff told us the trust’s accessible communications team could provide printed information in a range of languages upon request.
Staff told us they would use an empty clinical room if a patient had an identified need and could not wait in the main reception area. For example, we were given an example of a patient with a learning disability who became anxious in the main waiting area. Staff offered the patient and their carer a clinical room to wait for their appointment. Staff also spoke with the clinician and asked them to prioritise the patient.

Interpreters offering both face to face and telephone interpreting could be pre-booked for patients that didn’t speak English. Staff told us some members of staff also spoke other languages and could be approached to act as an interpreter. Staff we spoke with were aware that there was a list of staff members who were able to offer translation services for patients.

The main reception area provided disabled toilet facilities. We saw these were clean and well maintained. The reception provided baby changing facilities for parents and carers. There was a water dispenser in the main reception area to ensure patients and visitors to the department had access to drinking water.

A few patients said there were no televisions with subtitles to occupy patients waiting in the outpatient reception area. A patient said, “Some hospitals have TV news. It can be a bit boring waiting.” Another patient said about the outpatient reception, “There is nothing for the kids to do; a lot of people who have appointments have kids.”

Learning from complaints and concerns

We viewed a data sheet that recorded the number of complaints in outpatient specialisms. Between September 2016 and September 2017 there had been a total of 236 complaints across outpatient specialisms. The specialisms with the highest number of complaints in the period were orthopaedics with 31 complaints; ophthalmology and cardiology with 25 complaints each in the period. The trust took an average of 35 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be resolved within 25 days.

Several of the complaints had no resolution date added, it was unknown at the time if this indicated they were incomplete or there was a deficiency in the data supplied. The data supplied did not allow for breakdown by core service.

Staff told us they spoke with patients regularly to prevent any concerns that patients or families had from escalating. There was a formal complaints process for people to use with investigation, and response to the complainant. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms. Staff told us most complaints related to waiting in the waiting room and waiting times for appointments.

In the outpatient department the general information board displayed the complaints procedure.

Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the departments we visited. We also saw leaflets on PALS services in the main reception, patients could take these away to read at home. Staff had access to an easy read complaints policy for people who required information in this format.

Staff in the outpatients department told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If it could not be resolved by the team, staff told us people would be given the contact details of the patient advice and liaison service (PALS).
The clinical governance meeting reviewed complaints monthly. For example, the July 2017 meeting minutes recorded that complaints were being handled within the trust’s policy timescales. The minutes also identified trends from complaints as waiting times and rescheduling appointments.

Weekly complaint review meetings were chaired by the deputy managing director and director of nursing. The service informed us the meetings monitored the progress of complaint responses and had improved the response rate.

We viewed the complaints log for post-acute group division. We saw that complaints were regularly reviewed and trends monitored and identified.

### Is the service well-led?

#### Leadership of service

Overall, staff said there was an improving picture in regards to management of outpatients at the PRUH. The service managers had overall responsibility to co-ordinate outpatient services.

They were accountable to the deputy managing director for PRUH. The service manager met with the deputy managing director weekly. Most staff in the outpatients department told us the service managers were approachable.

A few senior and middle managers we spoke with told us the executive team and clinical director were not visible. Some lower grade staff also told us they did not know and were not sure they had seen any of the board. We viewed the ‘Tier 3’ service manager management structure flow chart. This clearly detailed the lines of accountability from service managers to the deputy managing director. However, it did not detail the structure of management at ward level including the outpatients’ matron. This meant staff could not follow the structure of management in the outpatients department from viewing the flow chart from ward to board.

Some senior ward level managers did not have knowledge of performance in their areas of responsibility in terms of referral to treatment (RTT) and did not attend rates (DNA). However, the managers did understand the risks and challenges to the service.

Some senior medical staff and nursing staff told us they could use more support. For example, the outpatient matron had not had an appraisal in over two years and staff in cardiology said they were not sure about the involvement of the clinical director.

The matron was covering four trust sites. Some staff said this sometimes had an impact on the matron’s availability. The matron told us they did an average of one clinical shift a week on each site. They sometimes covered clinical shifts if one of the sites were short of staff. This meant there was a risk that the matron would have insufficient time to complete managerial tasks.

Monthly outpatients’ team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.

Most staff we spoke with felt supported and valued by their local team managers. Staff told us the outpatient matron was visible and they saw her when she worked clinical shifts. However, a few staff told us managers lacked ‘soft’ managerial skills. For example, a staff member in outpatients told us, “Managers are effective, but functional in their approach.”

#### Vision and strategy for this service


Managers told us the outpatients department was in transition and the outpatients’ strategy was in development. The strategy would be based on a demand and capacity model. We were told the model would streamline scheduling and reduce waits, as well as determining the staffing needs of the service in response to demand for services.

All of the staff we spoke with were aware of the trust’s vision and values. Staff told us the vision and values were publicised on the trust’s intranet. The trust values were, ‘understanding you; inspiring confidence in our care; working together; always aiming higher; making a difference in our community.’ There was also a ‘promise’ which gave staff practical examples of how the values had been put into practice, to serve as prompts for staff on how the values were exemplified in practice.

There appeared to be limited space for the outpatient department footprint to expand. It had occupied the same area since inception and private finance initiatives (PFI) limitations seemed to hinder any change to expand to meet the increasing demand for clinics.

**Governance, risk management and quality measurement**

The outpatients department were part of the post-acute care group division, with the divisional lead feeding back to the board.

There had been a service restructure in February 2017. Outpatients were assigned to the post-acute care group division at PRUH. Some staff told us they had not been informed about the transformation agenda and did not know what this would mean for their service. A member of staff told us, “Information isn’t always cascaded to clinical teams.”

The Chartwell unit had introduced a service dashboard to monitor quality and risk. This was monitored by service leads. We saw that across the trust the cancer service was meeting all performance standards in July 2017, with the exception of referral to treatment (RTT) incomplete performance.

The service was achieving 80% RTT incomplete performance, compared to a trust target of 92%. The trend for this was stable from October 2017 to July 2017.

The hospital had introduced a range of governance processes, but these were relatively recent and not fully embedded. We saw that scorecards for each division were discussed at the July 2017 clinical governance meeting for post-acute medicine. However, outpatient staff told us they did not have a dashboard or balanced scorecard. Staff told us this made it difficult to monitor key performance indicators (KPI) as information was not readily available. Staff said the Business Intelligence Unit (BIU) would provide information, but this was usually upon request.

We viewed the schedule of monthly post-acute group governance meetings. This was a calendar that listed the venues, leading specialisms, and reports that would be reviewed at each meeting. Meetings were scheduled regularly every month.

The clinical governance meeting minutes for July 2017 recorded that BIU data was inaccurate. The minutes also recorded that mortality data was inaccurate and depended on the coding, this was being investigated.

A service manager told us, “The operational patient tracking list (PTL) is not user friendly for getting did not attend (DNA) and referral to treatment (RTT) rates.”
Outpatients had a risk register which outlined risks to patients or the service being delivered. Risks on the registers had the date they had been added and were regularly reviewed. The risk register had 11 outpatient “associated” risks on the register.

Managers across outpatients told us that generally there was a lack of communication from the BIU.

**Culture within the service**

Some of the senior managers were either new in post or had been there for a short period. However, some staff told us more could be done by senior managers and the board to listen to their concerns about the growing demand on the service and the capacity required in dealing with this.

Most staff we spoke in the outpatient department reported that morale was variable across outpatients. Most staff we spoke with were positive about services and felt positive about their role and contribution to this. However, a few staff told us they did not feel fully consulted by senior managers on how they felt about service changes and what they would like to change.

Some staff also said they felt PRUH was not a trust priority and the Denmark Hill site tended to get more resources. For example, some staff told us there had not been resources at PRUH to roll an estates management system at the same time as Denmark Hill, and staff said some training was not offered locally and this meant staff had to travel to Denmark Hill to attend mandatory training.

There were mechanisms in place for whistleblowing. These were processes by which staff could safely and anonymously raise concerns about hospital practices or staff practices.

Staff in the outpatient department said they worked together as a team and supported one another. However, staff in the cancer data team told us there had been multiple changes in management. They described an episode where a senior manager was verbally inappropriate, in front of the team, with a staff member who had applied for a job elsewhere in the organisation.

Staff told us a culture of reporting incidents and concerns was encouraged. The electronic incident reporting system prompted staff to record whether duty of candour requirements had been fulfilled.

**Public and staff engagement**

We saw a poster in the outpatients reception, ‘How are we doing.’ However, this contained information dating from November 2015.

The outpatients department had introduced the Friends and Family Test (FFT). We saw the results of the FFT from September 2016 to August 2017. This recorded 87% of respondents were likely or extremely likely to recommend the service to their friends or family, this was the same as the trust’s benchmark of 87%.

Staff had access to independent and confidential counselling and support services via the hospital’s occupational health department.

The trust had introduced, ‘Freedom to Speak Up’ guardians’ initiative. These were members of staff that were trained to support staff in raising issues or concerns safely. Staff were aware of the guardians, but the staff we spoke with said they had not had reason to use the service.

Local outpatient managers told us, “The staff are good at getting on with it. But we are at the limits of our capacity.”

We viewed the staff workstream monitoring spreadsheet. This recorded work in progress on a number of initiatives to engage staff. For example, a black and minority ethnic (BAME) network
and reverse mentoring scheme had been launched on 14th July 2017. The first meeting of the group was scheduled for 13th September 2017.

**Innovation, improvement and sustainability**

Most of the staff we spoke with reported improvements at the hospital. However, the limitations of the hospital building presented challenges for the outpatients department in offering more clinics.

A lack of staff awareness on available performance information meant that staff could not plan improvements based on performance data.

**Annex A**
<table>
<thead>
<tr>
<th>Team/Ward/Satellite Name (If more than one type of service is provided at a location, list each service area/ward in a separate row)</th>
<th>Description of team/ward/satellite and services provided (no more than 150 words)</th>
<th>For inpatient services, include: Number of beds by ward</th>
<th>Patient group (male, female, mixed)</th>
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<tbody>
<tr>
<td>Chartwell</td>
<td>Cancer and specialist blood services</td>
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<tr>
<td>Coronary Care Unit (CCU)</td>
<td>Coronary Care Unit</td>
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<tr>
<td>Emergency Assessment Unit (EAU)</td>
<td>Emergency assessment unit for Adults and Children</td>
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<tr>
<td>Farnborough Ward</td>
<td>Respiratory ward</td>
<td>25</td>
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<tr>
<td>HASU</td>
<td>Hyper acute stroke unit</td>
<td>12</td>
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<td>Acute Stroke Unit</td>
<td>Step-down ward from Hyperacute Stroke Unit (HASU)</td>
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<tr>
<td>Medical 2</td>
<td>Respiratory ward</td>
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<td>Frailty Unit</td>
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<td>Elderly Care ward</td>
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<td>Medical ward</td>
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<tr>
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<tr>
<td>Medical 8</td>
<td>Cardiac and Medicine</td>
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<td>Medical ward</td>
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</tr>
<tr>
<td>Surgical 1</td>
<td>Elderly Care ward</td>
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<td>Mixed</td>
</tr>
<tr>
<td>Surgical 2</td>
<td>Elderly Care ward</td>
<td>20</td>
<td>Mixed</td>
</tr>
</tbody>
</table>

The Chartwell Ward provides a service to patients who undergo assessment, diagnosis and possible treatment for cancer including malignant and non-malignant haematology-oncology patients, oncology patients and palliative care patients.

Chartwell Unit 12

Chartwell Treatment Suite

Farnborough Day Ward
day ward for respiratory patients

Mixed
<table>
<thead>
<tr>
<th>No</th>
<th>Wards/Clinical Area</th>
<th>Current configuration</th>
<th>Number of Beds/Theatres/Rooms</th>
<th>Comments</th>
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<tr>
<td>1</td>
<td>S3 ASU (20)®</td>
<td>Acute surgical admissions</td>
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<tr>
<td>2</td>
<td>S4 (14)®</td>
<td>Short stay surgical beds</td>
<td>14</td>
<td></td>
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<tr>
<td>3</td>
<td>S5 (28)®</td>
<td>Long stay surgical patients - colorectal, bariatrics, general surgery</td>
<td>28</td>
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<td>4</td>
<td>S6 (20)</td>
<td>Urology</td>
<td>20</td>
<td></td>
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<td>5</td>
<td>S7 (28)®</td>
<td>Fracture NOF and Trauma patients</td>
<td>28</td>
<td>Cohorts medical outliers</td>
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<tr>
<td>6</td>
<td>S8 (16)®</td>
<td>Gynae</td>
<td>16</td>
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<td>7</td>
<td>DSU - PRUH</td>
<td>All Day surgery cases</td>
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<td></td>
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<tr>
<td>8</td>
<td>Main Theatres - PRUH</td>
<td>Trauma/CEPOD and Elective main Theatres</td>
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<td>1 theatre closed</td>
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<tr>
<td>9</td>
<td>PIU (14)</td>
<td>Used as overflow ward mainly for surgical patients</td>
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