Barking, Havering and Redbridge University Hospitals NHS Trust

King George Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. The trust covers three local authorities; Barking & Dagenham which has very high levels of deprivation, and Havering and Redbridge which are closer to the national average. Havering has a relatively elderly population by London standards.

King George Hospital is in Ilford. It is a modern local hospital providing acute and rehabilitation services for residents across Redbridge, Barking and Dagenham and Havering and some services to patients from South West Essex.

We inspected the trust in October 2013, and found there were serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. I recommended to the Trust Development Agency (TDA) that the trust be placed in special measures in December 2013.

Since the inspection a new executive team has been put into place including a new chair, new members of the board, a chief executive, medical director, deputy chief executive, chief operating officer and a director of planning and governance. The executive team has been supported by an improvement director from the TDA.

The trust developed an improvement plan ('unlocking our potential') that has been monitored and contributed by all stakeholders monthly and published. The purpose of this re-inspection was to check on improvements, apply ratings and to make a recommendation on the status of special measures.

Overall, this hospital requires improvement. End of life care services were rated as good, its Outpatients and diagnostic imaging service were rated as inadequate and all other services were rated as requires improvement. Of the five key questions that CQC asks, we rated the hospital as good for caring. We rated the hospital as requires improvement for safe effective, responsive and well-led.

Our key findings were as follows:

- Improvements had been made in a number of services since our last inspection.

Safe

- Safety was not a sufficient priority. There was a backlog of serious incidents and the quality of investigations into serious incidents lacked detail to ensure failings were understood and lessons were learned.
- There were insufficient systems, processes and practices to keep patients safe. Lessons were not learned and improvements were not made when things went wrong.
- Recruitment had been on-going however there was not always enough medical and nursing staff to meet the needs of patients.
- The management of medicines needed improving to ensure safe management and administration.
- Patient safety could be compromised due to the layout and the inadequate alarm system in the Phlebotomy clinic in Outpatients.

Effective

- Radiology staff felt that their competencies for CT scanning were not appropriately maintained.
- Patients' needs were assessed and care and treatment was delivered in line with evidenced-based guidance.
- Patient outcomes were varied.
- Pain relief and nutrition and hydration needs were assessed and met.
- Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were well understood by the majority of staff and part of a patients plan of care.

Caring

Summary of findings

- Some national surveys have found that staff were not always compassionate. In response, staff had focussed on involving patients, keeping them informed and treating patients with dignity and respect.
- During our inspection we saw and heard of compassionate and kind care and emotional support being provided.

Responsive

- Urgent and emergency, children and young people and outpatients services were not responsive to patients' needs.
- The emergency department was not meeting the national four-hour waiting time target introduced by the Department of Health.
- The hospital was persistently failing to meet the national waiting times target. Some patients were experiencing more than 18 weeks from referral to treatment time (RTT).
- Speech and language therapists were not trained to care for patients who had tracheostomies.

Well-led

- The trust are not committed to delivering all the measures in their published clinical strategy, which impacted on the delivery of services and the needs of patients, and staff morale.
- The new executive team was making improvements. The board was visible and engaging with patients and staff.
- The leadership and culture were open, transparent and focussed on improving services.
- The governance structures did not ensure that responsibilities were clear and that quality, performance and risks were understood or managed.

We saw several areas of outstanding practice including:

- The values of the trust - passion, responsibility, innovative, drive and empowerment (PRIDE) were well known and embedded in the culture of the people working at the trust.
- The new executive team were visible and engaged.
- There was lots of involvement from the local community and voluntary organisations. The foyer had lots of people giving information for patients and visitors about services in the local area.
- Patients referred for cardiology appointments were seen within seven days.
- The critical care outreach team provided a 'critical care follow up outpatient's clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their admission.
- The critical care outreach team had devised a tracheostomy discharge checklist for patient's leaving the hospital with a tracheostomy. The checklist supported teaching key competencies to patients, family and carers in how to support a person with a permanent tracheostomy.
- We observed the critical care team supporting patients and their families with their individual needs in a flexible, thoughtful, patient, considerate and caring manner; this support and care extended through to their colleagues.
- The end of life care service was patient focussed and end of life care needs was well understood by the majority of staff from all staff groups.

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

Importantly, the trust must:

- Have clear governance with integrated systems and processes to support staff to provide care and treatment safely.
- Ensure serious incidents are understood, investigated and lessons are learned promptly.
- Review systems for sharing good practice across the divisions and trust wide.
- Ensure compliance with all national guidelines and trust policies for medicines management.
- Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.

Summary of findings

- Improve the IT systems so they are up to date and the IT strategy is implemented and supports clinical staff to carry out their duties.
- Ensure all services for neonates, children and young people are responsive to their needs.
- Ensure the radiology is fit for purpose and fulfils its reporting timescales, particularly for CT scans.
- Continuously review staffing levels and act on them at all times of the day.
- Include a dietician as part of the critical care multidisciplinary team in line with the core standards for intensive care guidance.
- Comply with the Duty of Candour legislation.
- Display the numbers of staff planned and actually on duty at ward entrances in line with Department of Health guidance.
- Ensure safe management and administration of medicines.
- Ensure that all incidents including patient falls are accurately reported electronically
- Ensure that patients who sustain a fall receive a medical review in a timely manner.
- Ensure that medical outlying patients have an identified medical team to review their care and an agreed escalation plan in place
- Ensure that speech and language therapists are trained and competent to care for patients who have tracheostomies.
- Ensure that entries made by medical staff in patient records comply with the expected professional standards
- Ensure that medical staff in the Emergency Department receive appropriate supervision.
- Ensure adequate provision of resuscitation equipment in Outpatients.
- Ensure compliance with COSHH regulations.
- Ensure patient records are kept securely and that patient confidentiality is maintained.
- Ensure radiologists are confident and competent when performing CT scans.

In addition the trust should:

- Consider increasing the target rates for mandatory training.
- Review the accessibility of the radiology services and consider a duty radiographer structure.
- Continue to improve patient record availability at outpatient clinics.
- Review the environment in Outpatients to improve the waiting and reception areas.
- Consider ways to increase multidisciplinary team working within critical care.
- Consider ways to engage patients in providing feedback.
- Review the number of medical staff cover for the medical wards at night.
- Review the staffing levels on Ash Ward.
- Ensure that junior medical staff are aware of the trust's complaints procedure.
- Ensure that nurses understand the importance of the recommendations stated by the speech and language therapy team.
- Consider ways to increase multidisciplinary team working within critical care.
- The hospital should review its response to major incidents including equipment, staff training and practical testing.
- The Emergency Department should review its poor performance in FFT scores and develop a plan for improvement.
- The Emergency Department should ensure that all staff are fully consulted upon, and aware of future plans for the department.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Most of the time, patients were kept safe while in the department. However, the department did not have enough doctors and nurses to keep patients safe all of the time. At night, and when the department was busy, patients were at greater risk of suffering harm. Supervision and learning was insufficient. Staff were not released from their core duties to attend training and development opportunities, as necessary. Clinical supervision was inconsistent. We observed compassionate care and many patients were positive about their experience in the department. However, the department performed poorly in the NHS Friends and Family Test, with scores well below the England average, and showing no signs of improvement over the 12 months prior to the inspection. The hospital had not achieved the national four-hour waiting target of 95% of patients seen within this timeframe for more than a year, and usually averaged around 90% of patients seen within this time. Patients often had waits of four hours or more in the department and were waiting for long periods of time to be moved to an appropriate bed once it has been decided they should be admitted. The needs of children were well met by the paediatric department, and waiting times are much shorter for children. There was no clarity about the future of the department and when, or if, it might close in the future. There had been a great deal of movement at management-level, both in the department and at divisional-level. This instability had led to a lack of strategy and leadership. Despite the pressure of work and organisational instability, staff remained positive and demonstrated a desire to give good patient care.
Medical care	Requires improvement 	There was a backlog of serious incidents overdue for investigation which meant that the division had not identified any learning from these incidents to make sure patient safety was protected and that the risk of these incidents happening again was mitigated.

Summary of findings

Medical outlying patients (medical patients in non-medical beds) did not have an identified medical team to review their care or an agreed escalation plan in place. On one low dependency ward, we identified two newly admitted patients with high dependency needs, who had not been seen by a consultant in a timely manner.
The hospital was clean and staff observed good practice to make sure that the risk of the spread of infection was minimised.
Nursing staffing levels were appropriate, however, medical staffing did not meet recommended levels and job planning data we reviewed for medical staff for a period in February, showed that there were a few shifts that had no medical cover.
Several local guidelines were out of date with no date for next review.
Mental Capacity Act training was not part of the trust's mandatory training programme and staff knowledge of, and application of the act, was inconsistent.
Patients' pain relief needs were provided for and people's nutritional needs were met.
There was a strong commitment to multidisciplinary working. Each ward had a multidisciplinary team meeting which included doctors, nurses, occupational therapists and physiotherapists.
Nurses delivered care with compassion and kindness and we observed that patients were treated with respect.
On each ward we spent time observing how patients were involved in their care. We observed many examples of nursing, medical and MDT staff providing appropriate reassurance for patients and affording patients time. This included answering patient's questions about care and treatment and explaining to patients what would happen next.
Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so.
Patients had access to a range of specialist nurses and other professionals for emotional support.
There were a significant number of medical patients on non-specialty or non-medical wards.
The trust had acknowledged that there was a delay in responding to complaints in medical wards and this was on its risk register. Divisions who were

performing poorly on complaints handling (of which medical care was one) had been tasked with devising and action plan for how they would address their backlog.
There was a trust wide dementia team who were available to offer support and advice to people living with dementia, their relatives and staff. Some wards had dementia friendly environments of differently coloured bays to assist patients to remember their bays in the event of forgetfulness.
There was a learning disability nurse and Hospital Passports for people with learning disabilities.
There was no agreed clinical strategy which meant that the management of medical care services at the hospital were unable to effectively plan and deliver services in response to the needs of local people.
We found that there was a backlog of serious incidents that were overdue for investigation. This meant that the hospital were not responding and learning from serious incidents to protect patient safety and to mitigate the risk of the same serious incidents happening again.
Junior doctors told us that they felt "unsupported" and "overworked". Most ward-based staff told us that they were happy with their work and direct line management.

Surgery **Requires improvement**

There was a backlog in investigating serious incidents and, at the time of our inspection, 12 were over the 45 day target. The trust was taking positive action to investigate these.
Access and flow issues, such as theatre cancellations, bed management and supporting discharge were generally well managed. However, there was a referral-to-treatment backlog at the trust, which meant the trust was breaching national targets for these. The trust leadership was focused on addressing key risks to the service: reducing the backlog to outpatient appointments, improving referral-to-treatment times for surgery, and improving the IT infrastructure. We found a governance structure in place that provided leadership, quality checking and improvement. Many members of staff made comments on the improvements to the culture of the service.
We found good cleanliness, infection control and hygiene practices in place. Appropriate

arrangements were in place for recording the administration of medicines. We found good evidence to demonstrate the trust's adherence to evidence-based care and treatment. However, some audits had been abandoned and others had not been completed to the expected deadline.
Patients received effective pain relief through ongoing monitoring and specialist support. Nutrition and hydration needs were being appropriately assessed and monitored. Patient care was supported by competent staff who received annual appraisals. It was also supported by teams from a variety of disciplines. Patients and relatives we spoke with were happy with the care and treatment they had received.
We observed positive and respectful interactions between patients and staff. We found that patients' individual care needs were being met and quality of care audits monitored that care met individual patient need.

Critical care **Requires improvement**

Patients and relatives spoke highly of the care and treatment they received in the Intensive Treatment Unit and High Dependency Unit. They told us they were kept updated about their family member's progress using language they understood. Visitors to the ward were made to feel welcome and were encouraged to support their family member if they felt able to.
There were insufficient critical care beds available for the population served by the Barking, Havering and Redbridge University Hospitals NHS Trust in comparison with other London trusts. Capacity was high at an average of 95%. It was estimated that critical care bed shortages affected 100 to 200 patients across the trust each month, with patients experiencing cancellations of planned procedures and significant waits in A&E (or in the recovery unit) while waiting for ITU beds.
Changes in the acuity of patients and reduced staffing levels meant patients were not always supported on a one-to-one basis, as per national guidance. Despite the bed shortages and staffing levels, we saw that staff continually assessed the safety of the patients and only supported patients on the ward or in the recovery unit if it was staffed appropriately, ensuring the safety of the patients.

Summary of findings

Staff were aware of how to support patients and their families' individual needs. Staff spoke passionately about providing the best care they could to achieve the best results for their patients. Patient outcomes and mortality rates were within expected ranges when compared to similar services. Care and treatment was delivered by trained and experienced nursing staff. There was a clear reporting structure and staff told us they felt supported and confident in their role.

Temporary and newly-qualified staff had to achieve a set of core competencies prior to working with patients on an individual basis. Junior medical staff spoke positively of the support and learning they received from consultants.

There was little evidence of multidisciplinary team approach. Physiotherapists spoke with consultants and nurses daily about how to support patients, but access to other professionals was carried out on a referral basis.

All the governance meetings took place at Queen's Hospital and we found that the consultants did not have a strong grasp of governance, risks or concerns relating to the unit.

Most staff were not engaged with the trust's vision and were unaware of the senior lead's vision for critical care services. This was affecting morale, which the senior staff on the unit were managing.

The outreach team supported ward-based staff in the early identification of patients who were at risk of deteriorating and who may require an HDU or ITU bed. Critical Care Outreach Team (CCOT) also provided an outpatient clinic to support previous critical care patients in the months after their admission to ensure they continued to progress.

Services for children and young people

Requires improvement

Although staff were aware of the incident reporting system, incidents were not always reported. Paediatric resuscitation equipment was not always checked in some areas of the hospital. We found there was a lack of paediatric life support training for theatre staff who may be involved in treating a child or young person whose condition suddenly deteriorated.

Summary of findings

Not all records were stored securely and confidentially. There were issues around obtaining records and tracking temporary notes, which meant a full set of notes was not always available.
The service children experienced during visits to the hospital for phlebotomy did not meet their needs. There were limited resources available for children with mental health needs and no paediatric physiotherapist.
Paediatric services had a lack of developed governance systems which meant that risks were not always identified and escalated appropriately within the division to the patient safety team for appropriate management.
Staffing on Clover Ward was not always sufficient. However, specialist nurses were brought in as necessary to provide cover. Although an acuity and dependency tool was available to calculate ward staffing levels, the data was not always updated on the system.
Observation of interaction between staff and patients was very positive. Parents told us they were involved in discharge planning and told us they were very happy with the attention their children received while staying on Clover Ward.

End of life care

Good

Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion. Specialist palliative care team members were visible, competent, and knowledgeable. Staff we spoke with were aware of how to report an incident or raise a concern.
Medicines were managed appropriately. Nurses were able to describe safeguarding procedures and how these were used to protect patients from abuse.
There was a sufficient number of staff who received appropriate training. There were systems in place that helped to reduce inappropriate hospital readmissions and complaints were responded to appropriately.
There were systems in place for the routine monitoring of the quality of the service and the specialist palliative care team management had developed appropriate strategies and objectives to ensure continuous service improvement. Staff worked well as a team.

Summary of findings

The hospital performed worse than the England average in the National Care of the Dying Audit. The trust's policy did not clearly specify in which cases staff were required to complete do not attempt cardio-pulmonary resuscitation (DNACPR) forms or how long after the admission they had to complete them. End of life services provided at the hospital were limited, with teams being based at another hospital managed by the trust.

Outpatients and diagnostic imaging

Inadequate

Staff were not always reporting safety incidents.
The trust had stopped reporting referral-to-treatment (RTT) waiting times from September 2014 and was unable to evidence compliance with clinical commissioning group regulations.
The phlebotomy clinic was overstretched, with long waiting times and there was no capacity to prioritise fasting patients or children. Seating areas were cramped and the department was unable to seat all the patients waiting in the clinic. Patients attending the phlebotomy clinic had a particularly poor patient experience. Staff did not have an overview of the waiting area and patients were unable to ask for assistance when required.
There was a significant backlog in the reporting of x-rays and 15% of patient appointments were cancelled in 2013/14. Patient health records were not always available at clinics and the hospital used a high number of temporary health records.
Staff had failed to ensure that resuscitation equipment was checked and fit for purpose. We also found medications stored in the department, which had passed their expiry date.
Radiology and haematology were struggling to meet with the demands on the service, due to a lack of suitably qualified staff.

King George Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to King George Hospital

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. The trust has two acute hospitals: Queen's Hospital and King George Hospital.

Accident and emergency (A&E) departments operated from both of these hospitals. It also provides services from the Victoria Centre and Barking Hospital but does not manage them. King George Hospital was built in 1993 and is the main hospital for Barking and Redbridge. There are plans to reconfigure services from King George Hospital to Queen's Hospital.

The trust covers three local authorities; Barking & Dagenham which has very high levels of deprivation, and Havering and Redbridge which are closer to the national average. Havering has a relatively elderly population by London standards.

Our inspection team

Our inspection team was led by:

Chair: Ruth May, Regional Chief Nurse, NHS England (Midlands and East)

Head of Hospital Inspections: Alan Thorne, Care Quality Commission (CQC)

Inspection Lead: Damian Cooper, CQC

The team of 35 included CQC inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, anaesthetist, physician and junior doctors; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses', paramedic, an imaging specialist, outpatients manager, child and adult safeguarding leads, a student nurse; and experts by experience.

How we carried out this inspection

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

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

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

Detailed findings

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS Trust Development Authority, Health Education England, General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN); NHS Litigation Authority and local branches of Healthwatch.

We carried out an announced visit between 2 and 6 March and unannounced visits on Saturday 14 March 2015 and Friday 20 March 2015. We observed how people were being cared for and talked with patients, carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, midwives, allied health professionals, and administration staff. We interviewed senior members of staff at the hospital and at the trust. Approximately 45 members of staff attended our 'drop in' sessions to talk with a member of the inspection team.

The CQC inspection model focuses on putting the service user at the heart of our work. On one day during our inspection we had a stall within the hospital and approximately 25 people shared their views and experiences of the hospital services.

Facts and data about King George Hospital

Context

Areas covered Barking and Dagenham, Redbridge. Services provided Full range of general inpatient, outpatient and day-case. Services and a 24-hour Emergency Department and Urgent Care Centre.

Main commissioning CCG Redbridge CCG. Population served Approximately 240,000 people.

Life expectancy

Havering Approximately 75 for men and 81 for women in the most deprived areas in the borough.

Deprivation (out of 326 local authorities, 1st is most deprived)

Havering 177 / 326

Number of beds 298 (of which)

298 General and acute

8 Critical care

Number of staff employed 1,253

148 Medical

452 Nursing

654 Other

Level of bank/agency staff Reported to be 10.2% of all staff as at September 2013

Activity

Inpatient admissions - Excluding emergency admissions (2013/14): 24,895

Outpatient attendances (2013/14): 105,543

A&E attendances (2013/14): 97,736 (of which)

62,858 Type 1

377 Type 2

34,501 Type 3

Deaths in hospital (2013/14)

521

Bed occupancy

Average bed occupancy: Not available broken down by individual hospital site.

Incidents

Never events (2014) 1 (unexpected death)

Detailed findings

Serious incidents (2014) 36 (Includes 12 grade 3 pressure ulcers, 8 slips/trips/falls, two unexpected deaths and one child death).

CQC Inspection History

Number of inspections 23 (for the trust as a whole)

Most recent outcome King George Hospital was Compliant for all outcomes checked (1, 4, 5, 7 and 13)

Key intelligence indicators

Safety

- One never event in 2014 (unexpected death).
- 36 serious incidents in 2014(Includes 12 grade 3 pressure ulcers, 8 slips/trips/falls, two unexpected deaths and one child death).
- Clostridium difficile: A total of seven cases were reported by the trust between April 2014 and January 2015.
- MRSA: Trust level target for the year is zero. Two cases between April 2014 and January 2015.

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – no evidence of risk
- Summary Hospital-level Mortality Indicator (SHMI) – no evidence of risk

Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 45%, which was worse than the national average of 53%.
- The average Friends and Family score for inpatients was 77, which is better than the national average of 74. The response rate was 41%, which was better than the national average of 38%.
- CQC Adult Inpatient Survey– Two risks and one elevated risk were identified in the trust as a whole for the questions to the following questions. Risks: "Did you find someone on the hospital staff to talk to about your worries and fears?", "Do you feel you got enough emotional support from hospital staff during your stay?". Elevated risk: "Did you get enough help from staff to eat your meals?"

Responsive

- A&E, four-hour target – Average of 92% of patients seen within four hours in King George Hospital in 2014.
- Referral-to-treatment times – Referral to treatment rates better than both the standard and the England average up until November2013 at trust level. No data is available for after this date.

Well-led

- Staff survey 2013, overall engagement score: 3.70. Slightly worse than the England average of 3.73.
- The results of the 2013 NHS Staff Survey demonstrated that for Barking, Havering and Redbridge Trust, the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
  - as expected in 16 key areas
  - better than average in one key area
  - worse than average in 11 key areas
- The response rate for the staff survey was lower than the national average with a response rate of 33% compared to 49% national average.

What people who use the trust's services say

Friends and Family Test (FFT)

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 45%, which was worse than the national average of 53%.
- The average Friends and Family score for inpatients was 77, which is better than the national average of 74. The response rate was 41%, which was better than the national average of 38%.

NHS Choices ratings - King George Hospital

Overall 3/5 (172 ratings)

Staff co-operation 3/5 (167 ratings)

Dignity and respect 3/5 (169 ratings)

Involvement in decisions 3/5 (164 ratings)

Same-sex accommodation 3.5/5 (131 ratings)

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Currently we do not have efficient evidence to rate Effective in outpatients and diagnostic imaging

Urgent and emergency services

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

Information about the service

The adult emergency department (A&E) saw 80,000 patients in 2014/15. The paediatric emergency department was responsible for seeing and treating approximately 16,000 children during the same period. Patients who attended the hospital first saw a doctor or nurse from an independent provider who assessed if they need to attend the A&E department or if they were suitable to attend the Urgent Care Centre (UCC), which was not provided by the trust.

We visited all the areas within the department, which included: resuscitation (which provided three trolleys for patients with life-threatening conditions), major injuries or Majors (a 17-bed area for seriously-ill patients), minor injuries or Minors (six trolleys and one treatment room), the paediatric area (nine beds) and two observation wards consisting of nine beds. We spoke with 27 patients and 17 members of staff. We examined 34 sets of medical notes for patients who had been treated in the department.

Summary of findings

Most of the time, patients were kept safe while in the department. However, the department did not have enough doctors and nurses to keep patients safe all of the time. At night, and when the department was busy, patients were at greater risk of suffering harm.

Supervision and learning was insufficient. Staff were not released from their core duties to attend training and development opportunities, as necessary. Clinical supervision was inconsistent.

We observed compassionate care and many patients were positive about their experience in the department. However, the department performed poorly in the NHS Friends and Family Test, with scores well below the England average, and showing no signs of improvement over the 12 months prior to the inspection.

The hospital had not achieved the national four-hour waiting target of 95% of patients seen within this timeframe for more than a year, and usually averaged around 90% of patients seen within this time. Patients often had waits of four hours or more in the department and were waiting for long periods of time to be moved to an appropriate bed once it has been decided they should be admitted.

The needs of children were well met by the paediatric department, and waiting times are much shorter for children.

Urgent and emergency services

There was no clarity about the future of the department and when, or if, it might close in the future. There had been a great deal of movement at management-level, both in the department and at divisional-level. This instability had led to a lack of strategy and leadership. Despite the pressure of work and organisational instability, staff remained positive and demonstrated a desire to give good patient care.

Are urgent and emergency services safe?

Requires improvement

The department did not routinely assess or learn from incidents that occurred, which meant that potential risks or bad practices were not appropriately addressed. There were effective processes in place to ensure people were safeguarded.

The department had a process of rapid assessment and treatment (RAT) processes for the immediate review of patients who had arrived by ambulance. Patients were usually seen quickly by a clinician and were appropriately assessed based on their vital signs. However, when the department got busy, patients were not seen quickly and had to wait with ambulance staff until they could be assessed.

The department did not have enough doctors and nurses to keep patients safe all of the time. At night, and when the department was busy, patients could be at an increased risk of harm.

For the vast majority of mandatory training modules for nursing staff, the uptake was lower than the trust's own target percentage target, or the trust did not provide a figure for this staff group.

Incidents

- Staff knew how to report an incident and said they reported incidents frequently.
- Staff told us that they were discouraged from reporting staff shortages as formal incidents. We were told that staff shortages were recorded in a daily log instead of being reported as incidents.
- We examined the entries in the daily log for the ten days prior to the inspection and found that on four of those days staff had recorded either medical or nursing staff shortages. Incidents which affect patient care or safety should be formally reported so that management are aware of the problem. Staff should take ownership of these concerns and provide a solution.
- The department had reported several serious incidents in 2014, which arose due to ambulance handover

delays. As a result, the department had been issued with a warning letter by the ambulance service, requiring it to develop an action plan to ensure that delays in handovers were reduced.

- At the time of our inspection, there was a backlog of nine serious incidents, across the trust's emergency care services, which had not been investigated within the agreed timescales.
- Staff were able to give examples of incidents they had reported. For example, one nurse told us that they had filed an incident report when there were four patients in the three-bed resuscitation area.
- Nursing staff told us they did not routinely receive feedback on the incidents they had reported. One nurse described a fall that had occurred on Observation Ward B a few weeks prior to our inspection. They told us that they had reported it as an incident, but they had not received any feedback on what had happened as a result of reporting it.
- Staff were, however, able to tell us about learning from some incidents. For example, a case where a patient had suffered complications following a paracetamol overdose was well known by the staff we spoke with, and they were aware of the learning from this incident and what action they might take, as a result of that learning in the future.
- The trust had reported no pressure ulcers or urinary tract infections between July 2013 and July 2014, and only two falls during the same period. However, two nurses we spoke with told us that they had frequently reported pressure ulcers. If the trust did not record these instances of patient harm, it would not be able to reduce the risks to patients in a planned way.
- We examined the minutes for the department's Mortality and Morbidity (M&M) meetings and found that the last meeting had taken place in November 2014. Staff confirmed that M&M meetings had not taken place since this date.

Cleanliness, infection control and hygiene

- All areas of the A&E were visibly clean and tidy. We examined six trolleys in different parts of the department and also the mattresses on them. They were all clean and well maintained.
- Cleaners we spoke with were very clear and precise about their role and how it should be completed. Records were kept in toilets to show they cleaned them at three set times each day at 7am, 12pm and 6pm, but no other cleaning records were kept. Staff we spoke with told us that the toilets were also cleaned at other times, when necessary.
- We saw that staff used protective clothing appropriately, regularly washed their hands and used hand gel between caring for patients and when moving from one clinical area to another. We observed that staff complied with the 'bare below the elbows' guidance. We found all the hand gel dispensers to be well stocked.
- Some staff told us that doctors did not always adhere to 'bare below the elbows' guidance, but we did not observe any doctors who were not following this guidance.
- In 2014, the Care Quality Commission (CQC) conducted a survey of A&E patients across the country. One of the questions people were asked was: "In your opinion, how clean was the A&E department?" The trust scored worse than average in the survey.

Environment and equipment

- Staff told us that they were concerned that the layout of the department meant that in Majors they had poor visibility of patient cubicles and seated patients in the sub-waiting area. Staff told us of an incident where a patient had collapsed in the Majors seating area and had not been immediately observed by staff because of the inappropriate layout of the department.
- We found that regular checks had been completed on equipment to ensure that it was working correctly.
- We checked the resuscitation trolleys and found them to be appropriately stocked and maintained. They were checked at each shift change with records kept to show the checks took place.
- The side bars on trolleys to protect patients from falling were all working correctly.

Medicines

- For the ten sets of notes we examined, doctors had correctly recorded their prescriptions and there had been a first and second check completed.

Records

- Medical and nursing records were kept together in a single set of patient notes, which were kept securely in a trolley by the nursing stations. We examined 12 sets of

patient notes and found that initial clinical observations, such as pulse and blood pressure checks, were recorded when patients presented to the department.
- For the 12 sets of notes, we found that falls assessments had not been completed. Two patients had been admitted following a fall in their own home, which should have triggered the staff to complete a fails assessment form for them.
- We found that discharge summaries were completed as necessary, which ensured that patients' GPs had the information they needed to provide appropriate follow-up care. Notes were legible, signed and dated.

Safeguarding

- There was evidence that the department were focused on child and adult protection. All children who attended the department were immediately assessed to identify if they were 'at risk'. The paediatric department had access to social workers and a health visitor team who were located within the hospital.
- The department had a safeguarding screening tool as part of the booking in process. This not only helped to identify if the patient was at risk, but also if anyone related to the patient could be at risk. It would identify, for example, if there were unattended young children at home or if a patient's partner could be at risk from the patient.
- The paediatric unit had effective working relationships with other professionals in the hospital and in the wider community. We found that for ten sets of paediatric patient notes that we looked at, they all documented that the safeguarding screening process had been completed. We observed that staff were asking appropriate questions of patients and carers to identify any potential safeguarding concerns.
- Staff in the paediatric and adult departments had up-to-date level 1 safeguarding training and demonstrated a good level of knowledge of child protection issues.
- Staff we spoke with had a good understanding of safeguarding concerns for adults also. Access to information on how to report a concern was available and displayed on boards in the department.

Mandatory training

- We examined the training records for the department and found that most staff were up to date on mandatory training, such as basic life support and infection control.
- Staff told us that they had undertaken mandatory training on their induction in the department and had received refreshers at regular intervals.
- For nursing staff in the department, 95% of this staff group had attended level 2 safeguarding training for both children and adults, but for the vast majority of all other mandatory training modules, the uptake was lower than the trust's own target percentage. The trust did not provide a figure for this staff group for modules, such as moving and handling, fire safety, health safety and welfare, equality diversity and human rights.

Assessing and responding to patient risk

- Many of the cubicles were being used by two patients instead of the one patient they were designed for. This meant that not all patients had an accessible call bell to request assistance if they needed it. Staff told us that as an interim measure, patients were being given small hand bells to use. Staff told us that there was a plan to install a call bell for every bed.
- We observed that many of the patients did not have access to a call bell. We did not observe that any of these patients had been provided with a hand-held bell.
- In the CQC 2014 patient survey to the question: "Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?" the trust performed worse than average.
- Staff told us that, often, too many ambulances would arrive within a short period of time. As there are usually only two nurses available to undertake initial assessment, patients had to wait on trolleys with ambulance staff. In the last winter period there were 374 delayed handovers of over 30 minutes from ambulances.
- The department had a process of rapid assessment and treatment (RAT) for the immediate review of patients who had arrived by ambulance. This process was undertaken by specific nursing staff. The process ensured that patients received a clinical handover from the ambulance service and an early clinical assessment. We observed this process and found that the nursing staff took all the appropriate observations and correctly applied the department's 'risk scoring' system.

Urgent and emergency services

- Rapid assessment and treatment nurses we spoke with said that they had been given additional training to perform the role and were able to describe the correct escalation process for patients, depending on the seriousness of their condition. Patients would be classified by the nurse as needing to see a doctor immediately, within ten minutes, within one hour or within two hours.
- Walk-in patients were seen by a streaming doctor or nurse, who decided if they were suitable for the Urgent Care Centre (UCC) or if they needed to go to the main emergency department. If the doctor or nurse decided they were suitable for the UCC, a receptionist then entered their personal details onto the computer with a few words setting out the patient's condition. If the patient was not appropriate to be seen by the UCC, they were seen by the triage nurse from the A&E department, who assessed their condition.
- We found that the department used a recognised National Early Warning Score (NEWS) to assess patients and identify if their condition was deteriorating. Staff we spoke with were aware of the process and made frequent records of patients' vital signs. We examined ten sets of notes and found that all of them had appropriately completed NEWS monitoring forms.
- Doctors we spoke with told us that they were appropriately called by nursing staff to see deteriorating patients, as necessary. None of the doctors were able to give an example of when they felt they should have be called to a patient, but had not been.
- In the paediatric department, we found that a Paediatric Early Warning Score system (PEWS) was being used appropriately. We found that in the ten sets of notes we examined, vital signs had been recorded and scores were recorded.
- In the case of a cardiac arrest, staff told us that the hospital resuscitation team would be called by dialling the '222' phone number. Staff told us that, although this meant every on-call medic in the hospital would immediately go to the department, the main reason this was done was to ensure the rapid attendance of the on-call anaesthetist.
- The paediatric department had a sepsis (a life threatening condition resulting from infection) trolley which contained all the necessary drugs and equipment to treat sepsis. The trolley also contained an up-to-date set of protocols.

Nursing staffing

- There were not enough nurses to keep patients safe and to ensure that patients were cared for at all times. Nursing staff in the Majors area were working to a ratio of one nurse to six patients. The matron told us that they felt the ratio should be one to four to improve patient care. The matron was not aware of when an acuity assessment was last completed for the department to establish their nursing requirements.
- The department had an establishment of 13 registered nurses during the day and ten at night. In addition, there were two registered nurses on a twilight shift from 6pm to 2am. Managers told us that there were often two or three nurses short on a shift. These numbers are sometimes made up by taking staff from other wards in the hospital, and by using bank or agency staff, but this was not always possible.
- We examined nursing staffing rotas for the two weeks prior to our inspection and found that the department was fully staffed on very few occasions over that period.
- Managers told us that the department had four vacant nursing posts and the trust was constantly trying to recruit new staff. In addition, two registered nurses were on long-term sick leave at the time of our inspection.
- In addition to nursing staff, there was one healthcare assistant (who worked three long days each week) and two accident department assistants during the day and one at night, who undertook activities such as taking blood samples, Echocardiograms, making sure patients had food and drink and that they were able to go to the toilet.
- Staff told us that when there was not a full complement of nursing and support staff. We were told that, when the department was very busy, staff would work very hard to make sure that patient care and treatment did not suffer.
- The department has two part-time emergency nurse practitioners working 20 hours and 24 hours a week each. There were no advanced nurse practitioners.
- The paediatric department had two paediatric nurses on duty on the day and one at night. They are also supported by a healthcare assistant at all times. Guidance states that the department should have two paediatric nurses on duty at all times. Staff told us that sometimes they could not get a paediatric nurse, so they would use general A&E nurses who had some experience in paediatrics.

- We examined the nursing rotas for the paediatric department and found that, for two shifts for the upcoming week there were no paediatric nurses available.

Medical staffing

- There was sufficient medical cover in the department for it to be safe most of the time. However, at night, and when the department was very busy, there was sometimes not enough medical cover.
- The Royal College of Emergency Medicine recommends that an A&E department should have enough consultants to provide cover 16 hours a day, seven days a week. The trust met this recommendation Monday to Friday at the time of our inspection, with a consultant always on duty between 8am and 12am. However, at weekends, there was only one consultant on duty providing eight hours of cover each day between 12pm and 8pm. Outside of these hours, there was an on-call consultant who was shared with Queen's Hospital.
- Staff told us that there was good medical cover in the paediatric department and paediatricians would attend from the main paediatric ward (Clover Ward) whenever they were needed. We observed paediatricians working in the department. Staff told us there was a very good working relationship between the paediatric A&E and the main paediatric ward.
- Consultant staff were shared with Queen's Hospital. There were eight permanent consultants in post from a target establishment of 16 consultants. In addition, there were two paediatric A&E consultants who spent most of their time at Queen's Hospital.
- In addition to the consultant cover, there were always two 'tier 1' (more senior middle grade) and two 'tier 2' doctors on duty from 8am to midnight. Between midnight and 8am there was always one tier 1 doctor and two tier 2 doctors.

Major incident awareness and training

- Staff and managers displayed a limited understanding of the major incident procedures for the department. They were not immediately able to locate key equipment, such as an inflatable decontamination tent.
- None of the staff we spoke with had undergone major incident training. One member of staff told us they were due to have a training session in April 2015.
- We examined the department's training schedule and found that major incident training had been planned for April 2015.
- Staff told us that there had not been a major incident exercise at the hospital for at least 16 years. No one was aware of who the major incident lead for the department was.
- Security staff were based within the department at all times. They were able to provide additional support for nursing staff where patients required one-to-one observation, due to actual or potential violence and aggression.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The department followed national and local guidance, including guidance published by the Royal College of Emergency Medicine (RCEM). However, the department performed poorly in a number of RCEM audits and there was little evidence that most staff were aware of this, or of how performance could be improved.

Supervision and learning was limited. Staff were not being released from their core duties to attend training and development opportunities, which should ultimately lead to better patient care. Clinical supervision was inconsistent.

There were some good examples of multidisciplinary working around elderly care and mental health. However, there were no clear relationships or protocols for GPs wishing to obtain advice or refer patients to the department.

Evidence-based care and treatment

- The A&E department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine guidelines to determine the treatment they provided. Local policies were written in line with this guidance, and were updated regularly.
- There were specific treatment pathways for certain conditions. For example; sepsis, fractured neck of femur,

acute cardiac syndrome, renal colic and head injury. We found evidence in patients' notes that the fractured neck of femur and sepsis pathways had been correctly followed.

- We looked at the way the department dealt with patients who had sepsis. Staff told us that they had all received recent training on identifying and treating sepsis. Staff displayed a good level of knowledge about treatment options.
- The hospital did not have specialist doctors for key areas such as ophthalmology and gynaecology on site. This meant the A&E doctors had to deal with these conditions themselves rather than being able to ask a specialist to attend the patient. Doctors we spoke with told us that they were able to effectively treat these patients and, in exceptional circumstances, specialist doctors would attend from Queen's Hospital.
- The outcomes recorded by the department for these specialist areas were no worse than for patients who had attended the A&E at Queen's Hospital.
- The paediatric department had recently reviewed and updated its pathways. For example, there was a clear pathway for croup. Paediatric clinical guidelines had also been updated.

Pain relief

- Five of the patients we spoke with had been in pain during their attendance. They all told us that they had been given pain relief very soon after arriving at the hospital. Staff we spoke with were aware of the appropriate guidance on providing pain relief to patients.
- One of the patients told us, "I was in a great deal of pain when I came here, but they gave me something for it in six minutes."
- We examined ten sets of patient notes and, in only one of these, we found that a pain chart had not been completed.

Nutrition and hydration

- There was a risk that patients would not receive appropriate nutrition while in the department.
- The department employed a healthcare assistant (HCA), who was responsible for ensuring that patients were offered hot or cold drinks and sandwiches. However, we were advised that there was only one HCA who worked three long days a week. This meant that, at most times, nurses and accident department assistants (ADAs) were responsible for ensuring patients received food and drink. The nurses and ADAs we spoke with were all aware of this responsibility, but most of them told us they did not always have the time to get food and drink for patients.
- One of the family members we spoke with, who had been in the department for eight hours, told us, "My mum was never offered anything to eat or drink, the nurses have been too busy."
- We examined 10 sets of patient notes and found that, although it had been recorded that patients had regularly been offered food and drink, there was no record of what patients had consumed.

Patient outcomes

- The department managers did not have a good knowledge of how the department had performed in clinical audits and were not able to provide examples of how practice had improved as a result. Senior clinicians were uncertain about which audits were currently being undertaken.
- The department performed well in the Royal College of Emergency Medicine (RCEM) vital signs audit.
- The department performed below the England average in the RCEM Audit of Renal Colic, which identified poor pain evaluation and pain relief for patients.
- There was no stroke team at the hospital. Most stroke patients would be taken directly by ambulance to Queen's Hospital and would not be brought to the department. However, there would be occasions when stroke patients would be brought in by ambulance or would walk into the department. The absence of a stroke team meant that patients who experienced a stroke in the department may have had worse outcomes than patients taken to, or presenting at Queen's Hospital.
- The unplanned re-attendance rate to A&E has been consistently worse than the 5% target and the England average since January 2013. This could be an indication that patients were being discharged inappropriately.
- The mortality rates for the trust had not raised any cause for concern through the national monitoring process.

Competent staff

- One registrar told us that they had not been appraised by their consultant since 2013.

Urgent and emergency services

- Junior doctors we spoke with told us that there was weekly training between 12 noon and 2pm each Friday. However, they told us that they were often unable to attend the training as they could not be released from the department if it was too busy.
- Registrars we spoke with were not always clear who their medical supervisor was. One doctor told us their medical supervisor had left the trust two months ago and they had not yet been allocated to a new supervisor. Registrars we spoke with told us that they were not receiving regular supervision from their consultants.
- Nurses in the department had not been able to order a patient x-ray, as they hadn't been trained to. Managers told us that, from the 1 April 2015, staff would be given additional training in this area so that they can order x-rays. This would enable earlier diagnosis and, therefore, treatment for patients.
- The paediatric nurse on duty was not always trained to Advanced Paediatric Life Support (APLS) level. This created a risk to children in the event of an emergency.
- Education and training were unsatisfactory. Band 5 nurses were not able to apply plaster casts to patients who had suffered a fracture. Only band 7 and above nurses had been trained in APLS and European Paediatric Life Support.
- Staff exhibited a good level of knowledge. They were aware of NICE and Royal College of Emergency Medicine guidance. We observed clinical practice by both doctors and nurses and found it to be appropriate and in accordance with guidance.
- A junior doctor was able to show us where to find the guidelines on sepsis on the computer system and demonstrated a good knowledge in this area.
- All nursing staff we spoke with said they had undergone an annual appraisal over the 12 months prior to the inspection. Nursing staff knew who their line manager was. Most staff told us they enjoyed working in the department and all of them said they got on well with their colleagues.
- All of the paediatric nurses in the department were qualified in both paediatrics and emergency care.
- Staff said they had 'keep in touch' days three times a year. The December 2014 day had covered sepsis and mental health.

Multidisciplinary working

- We observed three handovers from the ambulance service to the department staff. The patient handovers were well structured and ensured that all the relevant clinical information about the patients was properly conveyed.
- We spoke with three members of the London Ambulance Service (LAS) during the inspection. They all told us that they felt this was one of the better hospitals for handing over patients. One person told us, "Personally I don't have any problems handing over here, it's better than most in the area and they treat me as a professional."
- Staff told us that GPs often referred patients to the department with incorrect or insufficient paperwork. We were shown three example referral letters where GPs had given insufficient clinical information about their patients. Staff told us that they would often receive inappropriate referrals from GPs. Managers were unable to describe any plans they had to improve the GP referral process.
- We observed that there was a good working relationship among the core staff of doctors, nurses and assistants in the department. One junior doctor told us, "It's nice working here, the nurses support me and give me advice if I need it."
- There was a pilot Enhanced Mental Health Liaison Team in post until July 2015. It consisted of eight psychiatric nurses and two psychiatrists based in the department. This service was provided by the North East London Foundation Trust and provided a 24 hours a day, seven days a week mental health assessment service. The service meant that patients with psychiatric needs were identified and treated at an early stage. One A&E nurse told us, "It's great having them in here; it means our psychiatric patients get much better care." The team also provided support to patients with drug and alcohol issues.
- A&E staff told us that they often faced resistance from their acute medicine colleagues in taking referrals. Staff told us acute doctors would insist on a full diagnosis before coming to see a patient and there would often be a delay in their attendance.
- There were no alternative pathways into the hospital. Every patient had to attend the A&E department. Departmental management told us there were no plans

to put alternative pathways, such as surgical and assessment units, in place. This meant that, admission for acute surgical and medical patients could take longer than if alternative pathways were implemented.
- There was a good relationship between the paediatric department and the local Child and Adolescent Mental Health Services (CAMHS) team, who were able to conduct an assessment in most cases within an hour.
- There were regular meetings between paediatric A&E staff and social workers from the local authority to exchange safeguarding information and ensure families were supported.
- The Frail Older Person Advisory and Liaison Service (FOPALS) operated seven days a week from 8am to 8pm. Its purpose was to identify frail elderly patients whose discharge was being delayed by social support factors, and who did not need the intensive medical care of a hospital environment. The service was nurse-led, supported by occupational therapists and closely with the hospital and local authority social workers. Staff told us that they felt the service was excellent, helped to reduce the demand for beds and also helped patients to move to the best environment for their needs as quickly as possible.

Seven-day services

- Both the A&E department and the UCC were open 24 hours a day, seven days a week. Consultant cover was maintained out of hours by an on-call rota where consultants could be telephoned for advice and, in certain circumstances, would attend in person.
- The pharmacy was open Monday to Friday from 8.30am to 5pm and on Saturdays from 8.30am to 12.30pm. The department kept a stock of common drugs to help with discharge outside of these hours.
- Radiology services were available at all times. Staff told us that that they could get quick access for A&E patients to the radiology department, which was located nearby. However, it could take up to three hours for a computerised tomography (CT) scan or a magnetic resonance imaging (MRI) report to be returned.

Access to information

- Staff had access to electronic patient records and this enabled them to view previous inpatient and outpatient attendances. This helped to ensure duplication did not occur, and that up-to-date information was available.
- However, staff told us that the IT system was not good at letting them view laboratory results and it did not allow them to track results.
- Staff told us that the IT systems were unreliable. We were told that one of the IT systems (PACS) had not been available from 2am to 4am on the Monday before our inspection. This meant that staff were unable to access radiology and laboratory results for patients.
- Staff told us the patient management system would often 'freeze' on the computer terminals. This made it much harder for staff to track patient locations and care pathways. During our inspection, we observed that the system froze for ten minutes.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff we spoke with had a good knowledge of the Mental Capacity Act 2005 and the implications of the act for the patients they cared for. Staff were able to describe incidents where the Mental Capacity Act 2005 had been applied.
- Patients we spoke with had always been properly asked for their consent when undergoing procedures. We found examples where consent had been recorded in patients' notes.

Are urgent and emergency services caring?

Requires improvement

We observed compassionate care and many patients were positive about their experience in the department. The staff were caring, but did not always have the time to care for patients.

The department performed poorly in the NHS Friends and Family Test, with scores well below the England average and showing no signs of improvement over the 12 months prior to the inspection.

The relatives' room in the department was not fit for purpose and was an unsuitable environment for distressed family members.

Compassionate care

Urgent and emergency services

- The A&E NHS Friends and Family Test survey highlighted that the trust was performing well below the England average from April 2013 to July 2014, where they scored an average of 25 compared to an England average of 55.
- In the CQC A&E survey undertaken in 2014, the trust performed worse than other trusts for 13 of the 24 questions that related to the Caring domain. Overall, they were ranked '140' out of 142 trusts.
- We spoke to 27 patients and the vast majority of them told us that they were happy with their care. They told us, "It is much better than it used to be, they do their best." And another person said, "I have received excellent care and a superb welcome."
- We found examples where patients raised concerns about their care. One patient told us, "The nurses just don't seem to be able to cope, there are too many patients for them. If you need to speak to a nurse, it's hard to find one."
- It was good practice for the A&E department to undertake 'comfort rounds' where people were asked at regular intervals if they needed something to eat or drink or if they needed support with going to the toilet. When asked about this, a senior manager told us that this should have been undertaken every hour. Staff told us that they were aware of the need to undertake comfort rounds every hour, but when the department was very busy this did not always happen.
- We observed that, when patients who had walked into the department were being booked in, their conversations could be easily overheard by other patients seated in the waiting area. This meant that their privacy was not protected.
- We observed good care being given to patients in a friendly and considerate manner. We also observed that people's privacy was respected, with curtains being drawn when personal care was being given. Staff also lowered their voices to prevent personal information being overheard by other patients. However, because patients were often 'doubled up' in cubicles, it was impossible for a private conversation not to be overheard.
- All the children and their parents or carers we spoke with were very positive about the care they received in the children's area of the A&E. We found that staff were very caring and able to meet the needs of patients.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care. One person said, "Yes, I know exactly what is going on." Another said, "I am just waiting for my blood test results, then they will tell me what is going to happen." Patients had a good understanding of their conditions and had been given treatment options by clinicians.
- Parents accompanying their children in the children's A&E were positive about the treatment their child received. They said that the nurses and doctors had been understanding and supportive. One parent told us, "I have no complaints, they have been very kind to me and my daughter."

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

The hospital had not achieved the national four hour waiting time for patients being admitted or discharged. The target of 95% had not been met for more than a year and usually averaged around 90%. Patients were spending too long in the department and were waiting too long to be moved to a bed once it had been decided they should be admitted.

The needs of children were well met by the paediatric department, and waiting times were much shorter for children in the department.

Complaints were taken seriously and staff investigated them properly and kept patients informed of progress. There was evidence of learning from complaints that had been made.

Service planning and delivery to meet the needs of local people

- Trusts in England were given a target by the government of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The trust's performance with regards to waiting times was inconsistent and very rarely met the target. The department had not achieved the target for the twelve

months prior to the inspection, with the best monthly performance between April 2014 and January 2015 being 94% in July 2014, and the worst being 83% in December 2014.
- By agreement with the ambulance service, certain categories of patients were not taken to the department. These included children, certain cardiac patients, stroke and gynaecology patients.
- The department had not planned any specific pathways that allowed patients to avoid A&E. For example, many hospitals have surgical assessment units where patients can be directly referred by GPs.

Meeting people's individual needs

- Staff we spoke with were aware of the needs of patients living with learning difficulties. They described how they were aware of 'Hospital Passports' (a document which contains key information about how the individual should be supported, the person's behaviours, likes and dislikes) that patients might bring with them and how they would be used to establish communication by using these documents.
- However, in a focus group we held for people with 13 people with learning disabilities prior to the inspection, two people told us they had visited the A&E department and felt scared and apprehensive. They said that they were not kept informed of what was happening while in the department.
- We looked at the relatives' room, where people wait while their seriously ill relatives were being cared for, or where people were informed that a relative had passed away. We found it to be in an unsuitable condition, with old and worn seats, drab pictures and wallpaper. There was no telephone, tea and coffee facilities, or water cooler.
- Staff told us that if a relative needed supporting, they would ask the HCA to provide that support. Staff told us that the chaplaincy service was available 24 hours a day, seven days a week, but there were no other support arrangements in place.
- The trust provided a dedicated 24 hours a day, seven days a week children's emergency service and children were triaged in A&E. All children were cared for by children's nurses or nurses with experience in dealing with children.
- We observed that there was a separate reception window in the paediatric area. However, during our visit, there was a sign on it telling patients to go to the adult reception area.
- One patient from Lithuania told us that the first time he came to the hospital an interpreter was arranged and on the second occasion, he was offered the use of a language translation service (LanguageLine Solutions).
- Staff we spoke with were aware of the needs of patients living with learning difficulties. They described how they were aware of 'Hospital Passports' (a document which contains key information about how the individual should be supported, the person's behaviours, likes and dislikes) that patients might bring with them and how they would be used to establish communication by using these documents.
- Staff had a good knowledge about how to support people living with dementia. Staff had recently received training from a national dementia champion. Although the staff were aware of the 'Butterfly Scheme' (a not-for-profit organisation that provides training and templates to hospitals working with patients with dementia), there was no evidence it was being used in the department and no butterfly stickers were observed.

Access and flow

- At most times, the flow of patients from the department into other parts of the hospital was unsatisfactory. Most patients who were admitted to the hospital were transferred to the medical assessment unit (MAU). Staff told us that there were often no available beds in the MAU and, as a result, patients had to wait in the A&E department.
- We spoke with the nurse who was in charge of flow on the first day of our inspection. It was clear that they had a good understanding of the process and the current status of every patient. They told us that the rest of the hospital was often full, meaning that patients could not be moved out of the department.
- On the first day of our inspection at 11am, we found there were 41 patients in the department. Although most of the patients had been in for less than four hours, four of the patients had been in since before midnight and the longest waiting patients had been in the department for over 13 hours. This patient and four others had been admitted to the hospital, but there was no free bed for them so they could not leave the department.

Urgent and emergency services

- On the second day of our inspection at 10am, we found there were 20 patients in the department. Although most of the patients had been in for less than four hours, six of the patients had been in since before midnight and the longest waiting patient had been in the department for over 11 hours. This patient and seven others needed to be admitted to the hospital, but there was no free bed for them so they could not leave the department.
- There were a number of reasons that led to patients breaching the four-hour target. The two main reasons were a lack of beds on the MAU and the main wards and delays in specialist doctors attending to see patients in the A&E department.
- Patients who arrived by ambulance, other than those who needed to go immediately to resuscitation area, were seen by a rapid assessment and treatment nurse. This process ensured that patients received an early diagnosis by a clinician and increased the probability of a positive outcome.
- Patients who walked into the department were seen by a doctor or nurse at the front counter. They were then either streamed to the A&E department, or, if less serious, the UCC, which was open 24 hours a day, seven days a week and run by a separate provider.
- The department had an escalation plan which set out clear pathways and processes that needed to be followed if the demand for beds in the A&E increased. This covered the normal steady state and escalated to the declaring of an internal incident.
- The paediatric department kept a stock of common drugs so that they were available for patients who were being discharged. This reduced the delay to patients in going home.
- The department also had two small observation wards with three beds in one and six in the other. The criteria for admission to these areas were generally those patients with renal colic, frail elderly and, occasionally, psychiatric patients. However, staff were unclear about the criteria for patients in these areas. For example, the department documentation for the observation wards stated that psychiatric patients should never stay there, whereas, this was not the case in practice.
- Because of the delays in handing over patients, the London Ambulance Service had served a notice to the hospital requiring it to improve its receiving times.

Learning from complaints and concerns

- The department had a system in place for identifying, receiving, handling and responding to complaints and comments made by patients and those acting on their behalf. Complaints were initially dealt with by the matron. Publicity about complaints, in the form of leaflets and posters, was visible in the department. Most patients told us they would raise any concerns with a nurse.
- The matron was able to describe the seven complaints they had received in 2015. They were able to talk through how they had investigated a recent complaint. They were able to give details of their investigation and how the patients had been kept informed of the progress. They detailed the learning the department had gained from the incident.

Are urgent and emergency services well-led?

Requires improvement

There was no clarity among staff about the future of the department and when, or if, it might close. This made recruitment and retention of staff difficult.

There has been a great deal of movement at management level, both in the department and at divisional level. This instability had led to a lack of clarity and leadership.

Despite the pressure of work and the organisational instability, staff remained positive about their desire to give good patient care.

Vision and strategy for this service

- Staff knew that the corporate ethos was to take PRIDE (Passion, Responsibility, Innovation, Drive and Empowerment – the trust vision) in patient care, and aimed to provide great care to every patient, every day. The PRIDE vision was well known and accepted by staff.
- Staff in the department, were unclear about the vision for the future of A&E services in the hospital. They had been told on a number of occasions over the last four years that the trust intended to close the department.

Governance, risk management and quality measurement

- There had been a recent reorganisation for a new Acute Services clinical directorate which included A&E, FOPAL, integrated care and ambulatory care.
- There was a short team briefing meeting every morning at 7.30am, chaired by the matron and lead nurse to update staff on issues and deal with any operational concerns. There was a formal monthly meeting of nursing staff.
- Bed meetings were held across the trust at 8.30am, 12noon and 4pm and were chaired by the deputy chief operating officer. Some staff felt that the process was too centred on targets and sometimes, patient care was forgotten. For example, staff said that, occasionally, patients who were about to breach targets would be given priority.
- Clinical governance meetings for the trust were held on Wednesday afternoons. Medical staff told us that these meetings were poorly attended and senior medical staff we spoke with were unable to talk about what cases had been discussed and the learning from them. Staff were not informed about any learning from these meetings.
- We reviewed the minutes of the last three clinical governance meetings and found that there was limited attendance and key issues were not recorded as having been discussed.

Leadership of service

- There was a new matron and service manager who had been in post for only six weeks. There was a lack of clarity about who the leadership team was within the department. There were no regular management meetings. The clinical lead was not integrated into the leadership team.
- At a senior level, medical staff told us that they were unclear following the recent changes of senior management who the trust clinical director for A&E now was.
- Staff said that, other than the chief and deputy chief executives, they did not see the trust executive team very much. Staff did not feel supported by the trust or senior management. Staff said that when they were very busy during the winter of 2014, they felt that they had been left to survive on their own.

Culture within the service

- Staff within the department spoke positively about the care they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility, and all staff worked well across the A&E.
- Feedback from trainee doctors, who had been on placement in the department, was positive. They commented that they had been made to feel part of the team and that staff ensured they were able to be involved in all aspects of patient care and treatment.
- Nursing staff told us that the new matron and service manager were very visible and approachable. Staff said they felt they could go to them with issues, but that more senior managers were less likely to be helpful.

Public and staff engagement

- The department had low response rates for the NHS Friends and Family Test. Staff and managers were not aware of how well the department was performing in surveys and there were no plans in place to make improvements based on patient feedback.
- Staff said they did not feel engaged in the planning and development of the department. Staff felt that, as managers changed so often, it was difficult to establish relationships with managers and know what their plans were.

Innovation, improvement and sustainability

- The two new paediatric consultants had undertaken a complete review of the practices in the paediatric area, including a review of treatment pathways and protocols.
- Managers had identified that nursing staff were under-skilled and had established a programme to increase their skill levels. This included initiatives for ordering x-Rays, applying plaster casts and advanced life support.

Medical care (including older people's care)

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

Information about the service

At King George Hospital, medical care services were managed by the acute medicine clinical division, which included the specialties of acute assessment, ambulatory care, respiratory medicine, renal medicine, cardiology, gastroenterology, hepatology, diabetes and endocrinology. Older people's care was managed by the care of the elderly directorate. Medical care services at King George Hospital provided around 13,400 episodes of care in 2013/14.

To help us understand and judge the quality of care in medical care services at King George Hospital, we used a variety of methods to gather evidence. We spoke with 18 patients and five relatives. We spoke with 16 doctors, including: three consultants, 26 registered nurses (including ward managers and matrons), six healthcare assistants and ten Allied Healthcare Professionals, who were a mixture of occupational therapists, physiotherapists, speech and language therapists and pharmacists. We spoke with support staff, including domestic and catering assistants.

We observed care and the environment in which it was delivered and looked at records, including patient care records. We reviewed documents, including: audit results, action plans, policies and management information reports. During our announced inspection, we visited Ash, Beech, Fern, Gardenia, Gentian and Japonica Wards. We also visited the Clinical Assessment Unit and the Angio Suite.

We received comments from public and professional engagement, including focus groups we held with staff and a patient information stand we manned in the foyer of the hospital, and we reviewed performance information about the trust.

Medical care (including older people's care)

Summary of findings

There was a backlog of serious incidents overdue for investigation which meant that the division had not identified any learning from these incidents to make sure patient safety was protected and that the risk of these incidents happening again was mitigated.

Medical outlying patients (medical patients in non-medical beds) did not have an identified medical team to review their care or an agreed escalation plan in place. On one low dependency ward, we identified two newly admitted patients with high dependency needs, who had not been seen by a consultant in a timely manner.

The hospital was clean and staff observed good practice to make sure that the risk of the spread of infection was minimised.

Nursing staffing levels were appropriate, however, medical staffing did not meet recommended levels and job planning data we reviewed for medical staff for a period in February, showed that there were a few shifts that had no medical cover.

Several local guidelines were out of date with no date for next review.

Mental Capacity Act training was not part of the trust's mandatory training programme and staff knowledge of, and application of the act, was inconsistent.

Patients' pain relief needs were provided for and people's nutritional needs were met.

There was a strong commitment to multidisciplinary working. Each ward had a multidisciplinary team meeting which included doctors, nurses, occupational therapists and physiotherapists.

Nurses delivered care with compassion and kindness and we observed that patients were treated with respect.

On each ward we spent time observing how patients were involved in their care. We observed many examples of nursing, medical and MDT staff providing appropriate reassurance for patients and affording patients time. This included answering patient's questions about care and treatment and explaining to patients what would happen next.

Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so.

Patients had access to a range of specialist nurses and other professionals for emotional support.

There were a significant number of medical patients on non-specialty or non-medical wards.

The trust had acknowledged that there was a delay in responding to complaints in medical wards and this was on its risk register. Divisions who were performing poorly on complaints handling (of which medical care was one) had been tasked with devising and action plan for how they would address their backlog.

There was a trust wide dementia team who were available to offer support and advice to people living with dementia, their relatives and staff. Some wards had dementia friendly environments of differently coloured bays to assist patients to remember their bays in the event of forgetfulness.

There was a learning disability nurse and Hospital Passports for people with learning disabilities.

There was no agreed clinical strategy which meant that the management of medical care services at the hospital were unable to effectively plan and deliver services in response to the needs of local people.

We found that there was a backlog of serious incidents that were overdue for investigation. This meant that the hospital were not responding and learning from serious incidents to protect patient safety and to mitigate the risk of the same serious incidents happening again.

Junior doctors told us that they felt "unsupported" and "overworked". Most ward-based staff told us that they were happy with their work and direct line management.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

There was a backlog of serious incidents overdue for investigation which meant that the division had not identified any learning from these incidents to make sure patient safety was protected and that the risk of these incidents happening again was mitigated.

Medical outlying patients (medical patients in non-medical beds) did not have an identified medical team to review their care or an agreed escalation plan in place. On one low dependency ward, we identified two newly admitted patients with high dependency needs, who had not been seen by a consultant in a timely manner.

Safety Thermometer information reported on wards, did not correlate with the harm data reported by wards and recorded in patient records.

The hospital was clean and staff observed good practice to make sure that the risk of the spread of infection was minimised.

The use of multiple drug charts for patients presented a risk as some assessments were only recorded on one of the charts and not all of them, and each administration chart wasn't always completed before another chart was introduced.

We observed that nursing staffing levels were appropriate, however, medical staffing did not meet recommended levels and job planning data we reviewed for medical staff for a period in February, showed that there were a few shifts that had no medical cover.

Incidents

- There had been one reported Never Event in 2014, an unexpected death. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Medical care services reported 202 serious incidents requiring investigation between August and December 2014. These included patient falls, staff shortages and patient aggression towards nursing staff as recurring themes.
- We found that there was a backlog of serious incidents that were overdue for investigation by senior nurses. Senior nurses told us that there was no medical or governance lead input in to serious incidents requiring investigation. In addition, there was no evidence that learning had taken place and disseminated following investigation of incidents.
- Nursing staff told us they reported incidents electronically using the trust's incident reporting system. Senior nurses told us that feedback was given to those who reported incidents during staff meetings. However, several junior nurses told us that they received very little and often no feedback about the incidents they reported.
- A senior nurse told us there were about five patient falls per month on Ash Ward. We were told that these incidents were reported verbally at handovers and were "sometimes" reported via the electronic incident reporting system.
- Nursing staff told us that they found it difficult to get medical staff to review patients who had a fall during the night. They said they often had to wait for over two hours for a doctor to attend and sometimes the review of the patient took place via a telephone call only. One nurse told us that medical review following a fall was "not seen as a priority" by medical staff. As a result, some nurses told us that they initiated an observation plan including neurological observations until the patient was medically reviewed.
- We noted one clear example of inadequate medical review and failure to comply with the Duty of Candour legislation. A patient fell on Beech Ward in February 2015 and when medically reviewed by a junior doctor, no injuries were reported, despite the patient complaining at the time of neck pain and for a further three days. A consultant reviewed the patient prior to the weekend and imaging was not recommended. A junior doctor subsequently reviewed the patient after the weekend and decided that an x-ray and MRI should be carried out. Following these procedures, it was confirmed that the patient had a fractured neck and the family was not informed until the next day according to records. There was no documentation that duty of candour discussions and procedures took place with the patient and their family.

- There was minimal mortality and morbidity review activity within the acute medicine clinical division at the hospital and the trust were unable to evidence that these meetings were regularly held.

Safety thermometer

- Medical care services participated in the NHS Safety Thermometer scheme - a tool for measuring and monitoring patient harm. Data was collected on a single day each month to indicate performance in key safety areas such as patient falls, incidents of methicillin resistant staphylococcus aureus (MRSA) and pressure ulcers.
- There were Safety Thermometer boards displayed in ward corridors that had been introduced shortly before our visit. Prior to these boards, laminated forms were used.
- Safety Thermometer data was regularly returning nil values over a considerable period of time, despite many of the categories measured featuring regularly in incident reports. The data was not consistent with what was being recorded by the wards we visited and in the documents we reviewed.
- There were some positive examples of minimising the risks to patients who were susceptible to falls. If a patient was at risk of falling, they were identified with a sticker on the boards above their beds, patients had specific beds that were capable of being lowered to prevent them falling out and bed rails were placed in situ when appropriate. There was also a link nurse for falls on some wards and staff told us that the falls pathway was "much easier to follow".
- There was a tissue viability team who assessed and recommended a care plan for patients at risk of developing pressure ulcers. Average waiting times from referral from the wards to see the tissue viability team was two to three days.

Cleanliness, infection control and hygiene

- The hospital was visibly clean and well-maintained. Patients told us they were satisfied with the standards of cleanliness. One patient commented, "The ward is usually kept clean".
- Staff observed infection control principles such as being bare below the elbows and washing their hands before and after caring for patients. There were adequate hand-washing facilities and hand sanitisers for people to use. Information about hand washing and infection control was displayed in the clinical areas. Staff used personal, protective, clothing such as gloves and plastic aprons as required as a means of minimising the risk of the spread of infection.
- There were side rooms on each ward we visited for nursing patients that had infectious illnesses and we saw evidence that infection control audits including hand hygiene audits were conducted on wards.
- Equipment shared between patients such as commodes and intravenous stands were cleaned and labelled in between uses indicating that they had been decontaminated and were ready for use.
- We observed that clinical and domestic waste was segregated in different-coloured bags and waste in ward areas was correctly stored. Cleaning schedules were available and completed as required.
- Sharps management complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- In acute medicine, the number of cases of MRSA bloodstream infection between April and September 2014 was 0. The target set was for no cases. In acute medicine, the number of cases of clostridium difficile diarrhoeal illness between April and September 2014 was 16. The target set was for 37 cases.
- The hospital achieved a cleanliness score of 96% in the 2014 patient-led assessments of the care environment (PLACE). No concerns were identified regarding cleaning standards.

Environment and equipment

- The hospital achieved a score of 86% for condition, appearance and maintenance in the 2014 patient-led assessments of the care environment. Concerns identified included, the need to refurbish public toilets, a lack of bedside televisions and lack of the provision of radios. An action plan was in place and work to address these concerns was ongoing.
- We saw resuscitation equipment was readily available in each clinical area. There were systems to ensure resuscitation trolleys were checked daily to ensure they were ready for use on most areas. Records showed that staff complied with these systems. However, in the discharge lounge, the resuscitation trolley was not checked daily and was being signed to confirm that a laryngoscope handle was available but in fact it was not.

- The quality of cardiac monitoring equipment in the cardiac areas was identified on the acute medicine's risk register. We inspected this equipment and found it to be safe and in good working order. A junior doctor told us that the issues with the monitoring equipment in the Angio Suite had been improving as a result of more frequent safety checks.
- Staff told us that there was sufficient medical equipment in good working order to deliver safe care to patients.

Medicines

- We noted that some patients had multiple drug charts and venous thromboembolism assessments were recorded on one chart but not all, as they should be. The issue of multiple drug charts was an issue itself, because some charts were not fully completed, before others were started.
- A junior pharmacist told us that they were managing their workload, but junior pharmacists had to cover two wards, due to a lack of senior pharmacists. They stated that they had little support and that having to cover two wards resulted in a significant workload that often left them feeling "overwhelmed", particularly if there were several discharge medicines to be completed on the same day.
- One senior nurse told us that there were medicine incidents on the care of the elderly wards, whereby nurses recorded medicines as "unavailable" on patients' drug charts when the medicines were not on the ward at the time. They told us that this should not be done, as the medicine was usually available somewhere in the hospital. They said that this was a "training issue" for nurses.
- We looked at the prescription and medicine administration records for ten out of 59 patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed. If people were allergic to any medicines this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored and managed appropriately. Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them. A pharmacist visited all wards daily and checked that the medicines patients were taking when they were admitted were correct and that records were up to date.

Records

- Trust wide, 75% of nurses and midwives attended training on information governance in the year to November 2014. This was lower than the target of 85%. The figure for medical staff was 78%.
- Medical care services did not have integrated patient records for members of the multidisciplinary team to use. Nurses recorded their progress on patients care in a folder that was separate from the medical record shared by doctors and other healthcare professionals. This meant that all professionals involved in a patient's care could not see the patient's full record in one place and in a chronological order.
- We looked at patients' records and found they were mostly comprehensive, up to date and reflected the care and treatment patients received. However, there were instances where entries by medical staff were not dated or signed and deviated from the expected professional standards.
- Medical records were stored in lockable trolleys, usually in corridors beside the nurses' station. Although these trolleys were never locked when we visited, they were always within view of staff making unauthorised access unlikely.
- We saw that patients were risk assessed in key safety areas using national validated tools. For example, we saw that the risk of falls was assessed and the risk of pressure damage to the skin was assessed. We noted that when risks were identified, relevant care plans that included control measures were generated.

Safeguarding

- Training in safeguarding children and adults formed part of the mandatory training programme. Trust wide, 95% of nurses and midwives attended on safeguarding

vulnerable adults' level 2 in the year to November 2014. This exceeded the trust target of 85%. The attendance figure for safeguarding children and adults for medical staff was 57%, much lower than the target of 85%.

- Most nurses we spoke with knew how to raise concerns in order to safeguard the welfare of patients. Junior nurses told that they would escalate concerns to the nurse in charge of the ward.

Mandatory training

- Health, safety and welfare, and fire safety training formed part of the mandatory training programme. Trust wide, 95% of nurses and midwives attended health, safety and welfare training in the year to November 2014. This exceeded the trust's target of 85%. Trust wide, 75% of nurses and midwives attended fire safety training in the year to November 2014. This was lower than the target of 85%.
- Staff on most wards we visited were able to attend mandatory training apart from those on Ash Ward. We were told this was because Ash Ward was short of staff and there were not enough dates for some courses such as 'conflict resolution', which recently became mandatory.
- Staff were aware of the mandatory training they were required to undertake and attended a two-day mandatory training course every two years.
- Ward managers we spoke with demonstrated the systems they used locally to monitor attendance of their staff at mandatory training, in order to ensure training was completed and refreshed when necessary.
- 91% of nurses had completed sepsis training which was an improvement from our last inspection.

Assessing and responding to patient risk

- Medical outlying patients (medical patients in non-medical beds) on Beech Ward (Stroke) did not have an identified medical team to review their care or an agreed escalation plan in place. There was also lack of clarity about which medical team should review medical outlying patients on other wards and as a result they were often not reviewed in a timely manner.
- Japoinica Ward was a low dependency step-down rehabilitation ward and on two days during our inspection we found numerous outliers on this ward. We escalated concerns that at least two of the recently admitted outliers on one day had high dependency needs, and had not been seen by a consultant when we left the ward to escalate our concerns at approximately 11:30am that day.
- We saw that the modified early warning scoring system was consistently used whenever patient observations were taken. We looked at an example where the score had indicated a risk of deterioration, and saw that appropriate actions had been initiated in line with the trust's protocol.
- All patients had risk and needs assessment records completed, which included, recording of vital signs, urinalysis, nutrition and manual handling.
- Staff could access medical advice in relation to acutely unwell or deteriorating patients between 8am and 8pm.

Nursing staffing

- The numbers of staff planned and actually on duty were not displayed at ward entrances in line with Department of Health guidance.
- Some areas were fully staffed for example Gardenia Ward. Others were often short of one registered nurse or one healthcare assistant on a daily basis. Ash ward was particularly short staffed. There were five vacancies for qualified nurses; two healthcare assistants were on long term sick leave and a further two were on suspension. As a result, Ash Ward usually had two to three bank or agency nurses and healthcare assistants on duty per day. We were told that senior nurses recently went to Portugal and that they had recruited four nurses there who were due to start soon.
- Apart from Ash Ward, staff told us and we observed that staffing levels were appropriate for the acuity and dependency of patients. The ratio of nurse to patients on day shifts on Fern, Japonica and Gentian Wards was 1:7 or 1:8 and these were roughly in line with NICE guidelines**.** The main concern for staff was that sometimes staff were moved from their areas in order to fill staff shortages elsewhere.
- Handover of the care of patients took place twice per day between shifts. We observed one handover and noted that all patients, any incidents and any planned discharges were discussed. Board rounds were one type of handover and included members of the multidisciplinary team such as the matron, junior doctor, occupational therapist and physiotherapist.

Medical care (including older people's care)

- Patients and relatives had mixed views of staffing on the wards. Some felt there was adequate staffing but patients and relatives felt that Ash Ward and the clinical assessment unit were particularly understaffed.

Medical staffing

- We were told that night medical cover (9pm to 9am) on medical wards consisted of one specialty registrar and two junior doctors. This was less than recommended and resulted in some patients not being reviewed in a timely manner, particularly when the emergency department was busy.
- The medical staffing cover at night was described by junior doctors to be 'unmanageable' at times. We saw that there were regular gaps in the medical rota on the clinical assessment unit due to lack of staff and there was a high number of locum medical staff as a result.
- There was often no specialty registrar covering the clinical assessment unit and the consultant provided cover in such circumstances. However, we were told the medical staffing on Gardenia Ward was well managed with junior doctors 'cross covering' regularly.
- The ability to handover and medically review outlying patients on other wards was limited due to the reduced medical cover.
- We reviewed the job planning data for consultants and medical rotas for speciality registrars, junior doctors Foundation Year 1 (FY1) and trust grade doctors for the week beginning 23 February 2015. This showed that there were a few shifts that had no medical cover.
- Trust wide, there were 276 whole time equivalent (WTE) medical posts. Consultants represented 31% of the medical workforce in medical care services against the England average of 33%. Registrars represented 28% against an England average of 39%. This meant there the percentage of consultants and registrars when compared to the total number of medical staff employed were fewer than the England average.
- Although, the number of doctors in training had been reduced at the hospital, trust wide, junior doctors represented 33% of the medical workforce in medical care services which was better that the England average of 22%. However, junior doctors told us that they had to review between 60 and 100 patients each (excluding emergency department patients) and this high number meant it was difficult to ensure patient safety.
- A consultant on-call system was operated, but there was no out of hours consultant cover or weekend consultant-led ward rounds on Beech Ward. There was also no consultant cover after 4.15pm on the clinical assessment unit.
- On Gardenia Ward, we found that consultants reviewed patients seven days a week, with Saturday ward rounds and Sunday reviews if necessary.
- There was an orthogeriatric consultant in post who had clear protocols to follow in order to review relevant patients.
- There were enough Allied Healthcare Professionals such as physiotherapists and occupational therapists to deliver care to patients. Where there were vacancies, these were filled by temporary locum staff. However, there was a shortage of speech and language therapists cover, the service of which was provided by another trust.

Major incident awareness and training

- Staff we spoke with told us that they had not had major incident training or briefings and could not remember the last time there had been a drill at the hospital to practice how to respond to a major incident.

Are medical care services effective?

Requires improvement

Several local guidelines were out of date with no date for next review.

Patient outcomes were variable. For the National Diabetes Inpatient Audit (NaDIA) for September 2013, the hospital performed worse than the England average in 15 of the 22 standards. For the national audit of care of patients with non-ST segment elevation myocardial infarction (a form of heart attack) 2012/13, the hospital performed better than the England average.

Mental Capacity Act training was not part of the trust's mandatory training programme and staff knowledge of the act, was inconsistent. However, we saw evidence that when required, formal best interests meetings were held to establish patients' capacity and make decisions in people's best interests in line with the Department of

Medical care (including older people's care)

Health code of practice for implementing the MCA. When appropriate, staff also referred to independent mental capacity advocates for independent advice about best interest decisions.

Patients' pain relief needs were provided for and people's nutritional needs were met.

There was a strong commitment to multidisciplinary working. Each ward had a multidisciplinary team meeting which included doctors, nurses, occupational therapists and physiotherapists.

The majority of staff were appraised on their performance on an annual basis, and induction programmes for ward-based nursing staff were comprehensive.

Evidence-based care and treatment

- Several guidelines were out of date with no date for next review. Policies on community acquired pneumonia, non-invasive ventilation and management of diabetic ketoacidosis were all overdue for review. On Gentian Ward, staff were aware of NICE guidance that was relevant to caring for patients with gastro-intestinal illnesses, for example NICE clinical guideline 106 - Ablative therapy for treatment of Barrett's oesophagus and NICE clinical guideline 86 - Recognition and assessment of coeliac disease.

Nutrition and hydration

- Patients' records showed that they were assessed for the risk of malnutrition using a recognised, validated tool.
- When nutritional screening demonstrated a risk, we saw that appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to the dietician, were taken. Patients were assessed by a dietician when screening suggested a risk of malnutrition or there were medical problems that compromised patients' nutrition.
- The patient-led assessments of the care environment (PLACE) for the hospital in 2014 achieved a score of 89% for food. A concern identified was related to the provision of a patient meal service 'course by course' so that the patients were served their main meal and dessert separately. An action plan was in place and work to address this concern was ongoing.
- We observed that patients were served a choice of meals and dietary supplements were given to people when prescribed. Supplements were given to patients assessed as being at risk of malnutrition by nurses without the need for it to be prescribed by medical staff. We were told that twice daily rounds were carried out on the care of the elderly wards for patients whose dietary intake was poor.
- We saw that food charts were generally well completed to enable dieticians and nurses to monitor the nutritional intake of people at risk of malnutrition. Fluid balance charts were used and completed when required.
- Meal times were not protected and we found lunchtime to be noisy with many different members of staff, carrying out many different types of activities with patients. Healthcare assistants, catering assistants and student nurses assisted with the distribution of meals. We noted that patients were helped to eat and drink and were left with a drink within reach. A system was operated to identify those patients who required assistance with eating. Food that met people's special cultural and religious needs was available.
- Patients who had difficulty in swallowing were referred to the speech and language therapy team who assessed patients quickly.
- Intravenous fluids were prescribed for patients who were assessed to be dehydrated or who were not eating adequately.
- Most patients told us the meals were satisfactory, however one did lament about the lack of choice and variety of food on the ward.

Pain relief

- Patients we spoke with said that staff asked them whether they were in pain and gave them painkillers when they were required. One patient said, "My pain has been treated very well". Another said, "There's no problem with pain relief."
- We saw that assessments of patients' pain were included in all routine sets of observations and staff ensured that patients were comfortable as part of intentional rounding processes.
- Staff responded to patient's requests for painkillers and administered analgesia as prescribed. One nurse told us that if the painkillers were not effective in controlling the patients' pain, they would refer the patient to the pain team. However, we noted that when temporary bank nursing staff were on duty, patients waited longer for pain relief.

Medical care (including older people's care)

Patient outcomes

- The standardised relative risk of readmission for elective admissions (87) was better than the national expectation of 100. This meant that patients were less likely to require unplanned readmission, suggesting the hospital's care and discharge arrangements were appropriate. For non-elective admissions, the rate was slightly worse (101) than the national expectation of 100.
- In the latest Sentinel Stroke National Audit Programme (SSNAP) – audit data to September 2014 – stroke services at the hospital achieved a performance rating of 'B' on an A–E scale, where A is the highest.
- There was good occupational therapy and physiotherapy involvement with stroke patients.
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, the hospital performed worse than the England average in 15 of the 22 standards. The hospital performed worse for standards relating to foot risk assessments, meals and staff knowledge.
- In a national audit of care of patients with non-ST segment elevation myocardial infarction (nSTEMI – a form of heart attack), as part of the Myocardial Ischaemia National Audit Project (MINAP, 2012/13), the hospital performed better than the England average for patients who were admitted to a cardiac unit (95% against an England average of 53%); better than the England average for patients who were seen by a cardiologist or member of the team (98% against an England average of 94%) and slightly better patients than the England average for patients who were referred for angiography – 74% against an England average of 73%.
- In the National Heart Failure Audit (2012/13), the hospital performed equal to, or better than, the England average in seven out of 11 areas. Areas where the hospital performed worse included: cardiology inpatient care (28% against an England average of 50%) and prescription of angiotensin-converting enzyme inhibitors on discharge (55% against an England average of 73%). Areas where the hospital performed better included input from a consultant cardiologist (59% against an England average of 57%) and referral to cardiology follow up (63% against an England average of 53%).
- There was an audit programme for 2013 and 2014 for both acute medicine and care of the elderly wards. Audits completed included, 'Medical record keeping in line with the generic medical record keeping standards prepared by The Royal College of Physicians'; 'The use of early warning scores on the clinical assessment unit' and a 'Leg ulcer audit' on the care of the elderly wards.

Competent staff

- Staff told us that they were appraised on their performance on an annual basis. Figures provided for the previous financial year (2013/14) showed that 75% of staff were appraised in acute medicine and 71% of care of the elderly staff.
- We found induction programmes for ward-based nursing staff to be comprehensive. This included a six month probationary period and courses on medicine management, practical competency assessment and an intravenous drug administration course.
- On Gardenia Ward, nursing staff provided good support for junior medical staff including taking blood from patients when appropriate.
- Training and development opportunities for junior nurses were variable. While some commented that there were good development opportunities, others told us that they were "frustrated" with the lack of development opportunities and were considering either paying for courses themselves or moving to another clinical area.
- We were told that there were no speech and language therapists who were trained and competent to care for patients who had tracheostomies and as a result referrals for such patients were not accepted by the speech and language therapy team. We were also told by a speech and language therapist that very few nurses could perform swallow assessments on patients and as result, patients were left nil by mouth for longer than they should be. A speech and language therapist also told us that some nurses did not appear to understand the importance of the recommendations stated by the speech and language therapy team.

Multidisciplinary working

- There was a strong commitment to multidisciplinary working. Each ward had a multidisciplinary team meeting which included doctors, nurses, occupational therapists and physiotherapists.
- Ward teams had access to the full range of Allied healthcare Professionals, and team members described good, collaborative working practices.

Medical care (including older people's care)

- Ward teams told us and we noted that they had access to mental health services provided by another trust. Psychiatric assessments were carried out as a result of referrals.
- There were arrangements for a twice daily multidisciplinary handover of patients and we saw these in progress. Staff said they considered these handovers beneficial to keeping up to date with patients' progress.

Access to information

- Clinical staff told us they had access to current medical records and diagnostic results such as blood test results and imaging to support them to care safely for patients.

Consent, Mental Capacity Act and DoLS

- Capacity assessments were carried out by any member of the multidisciplinary team, depending on the specific decision to be made by the patient.
- Staff we spoke with gave a varied understanding about their responsibilities under the Mental Capacity Act 2005 (MCA). Some members of the multidisciplinary team were able to articulate their responsibilities under the act. However, there was one example on Gentian Ward whereby medical staff were not clear as to whether the capacity status of a patient should have been taken over the phone from the patient's existing consultant psychiatrist, or whether the baseline assessment should have been carried out in hospital.
- MCA training was not part of the trust's mandatory training programme.
- We saw evidence that when required, formal best interests meetings were held to establish patients' capacity and make decisions in people's best interests in line with the Department of Health code of practice for implementing the MCA. When appropriate, staff also referred to independent mental capacity advocates for independent advice about best interest decisions.
- We observed that staff gained patients' permission before giving care and treatment. We heard a nurse saying to a patient, "Are you ready to have a wash?" The patient responded, "Yes," and the nurse proceeded to prepare to wash the patient.
- There was a trust lead for Deprivation of Liberty Safeguards who provided support to staff as necessary.

Are medical care services caring?

Good

Nurses delivered care with compassion and kindness and we observed that patients were treated with respect.

On each ward we spent time observing how patients were involved in their care. We observed many examples of nursing, medical and MDT staff providing appropriate reassurance for patients and affording patients time. This included answering patient's questions about care and treatment and explaining to patients what would happen next.

Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so.

Patients had access to a range of specialist nurses and other professionals for emotional support.

Compassionate care

- Nurses delivered care with compassion and kindness.
- Patients expressed satisfaction with the care and treatment they received. Comments included: "I feel safe," and, "I can't fault it [the care]," and, "The treatment and attitude of staff has been really good," and, "[The staff were] absolutely wonderful." Visitors told us that they were happy with the care that their relatives received. One said, "The staff are fantastic."
- We saw 'Thank you' cards from patients and relatives displayed on Fern Ward. Comments included, "I wish to express my admiration and appreciation for the wonderful treatment I received," and, "I wish to express heartfelt thanks to all the staff that have cared for my mother."
- We observed that patients were treated with respect. Their privacy and dignity were maintained; for instance, we saw that care interventions were carried out behind closed doors or curtains, and staff asked permission before they entered patient's rooms.
- The patient-led assessments of the care environment (PLACE) for the hospital in 2014 achieved a privacy, dignity and wellbeing score of 71%. A concern identified was related to lack of privacy at the reception areas in the emergency departments. An action plan was in place and a scheme has been worked up to install partition walls, but this was dependant on funding.

Medical care (including older people's care)

- The results for the NHS Friends and Family Test averaged 47 out of 100 across seven medical care areas over the period of August 2013 to July 2014; the England average is 71. The NHS Friends and Family Test response rate was better (42%) than the England response rate of 30%.

Understanding and involvement of patients and those close to them

- On each ward we spent time observing how patients were involved in their care. We observed many examples of nursing, medical and MDT staff providing appropriate reassurance for patients and affording patients time. This included answering patient's questions about care and treatment and explaining to patients what would happen next.
- Patients' relatives told us they were encouraged to participate in care when it was appropriate to do so. One relative told us the doctors and nurses were "caring" and they gave them appropriate information when required. Another said "I do feel all my questions are answered".
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, 35% of patients reported that they felt able to take control of their diabetes care. This was lower than the England average of 54%.

Emotional support

- Patients had access to a range of specialist nurses and other professionals for emotional support.

Are medical care services responsive?

Requires improvement

There were a significant number of medical patients on non-specialty or non-medical wards.

The trust had acknowledged that there was a delay in responding to complaints in medical wards and this was on its risk register. Divisions who were performing poorly on complaints handling (of which medical care was one) had been tasked with devising and action plan for how they would address their backlog.

There was a trust wide dementia team who were available to offer support and advice to people living with dementia, their relatives and staff. Patients, whose presentation indicated, were screened for dementia. Some wards had dementia friendly environments of differently coloured bays to assist patients to remember their bays in the event of forgetfulness.

There was a learning disability nurse and Hospital Passports for people with learning disabilities.

Meeting people's individual needs

- On Ash Ward there were signs above patient's beds which stated that all patients over the age of 65 needed to be on a falls pathway. We did not see this sign on any other wards. This was a blanket approach and not responsive to the individual patient's need.
- Patients were accommodated in single-sex bays or single rooms. There were name boards on the walls behind patient beds that included details of their named nurse and consultant.
- Nurses and healthcare assistants answered call buzzers in a timely manner.
- There was a trust wide dementia team who were available to offer support and advice to people living with dementia, their relatives and staff. Patients, whose presentation indicated, were screened for dementia. The 'Butterfly Scheme' was in place whereby people diagnosed with dementia had a 'butterfly' logo on their name boards. Where possible, people living with dementia were placed in beds as close as possible to the nurses' station to enable vigilant observation. On Japonica Ward, there was a dedicated bay where female patients living with dementia were nursed. This bay was under continuous observation by a healthcare assistant. Staff told us that they had had training on managing patients with challenging behaviour and there was a dementia 'champion' or 'link nurse' on each ward.
- Some wards had dementia friendly environments of differently coloured bays to assist patients to remember their bays in the event of forgetfulness.
- There was a learning disability nurse and Hospital Passports for people with learning disabilities. One relative of a vulnerable person with a learning disability told us about their experience and spoke positively about the care provided.
- Mobility aids and lifting equipment such as hoists to enable staff to care for patients were available.

Medical care (including older people's care)

- A group of doctors told us that they could meet the communication needs of patients whose first language was not English through interpreting services via telephone or face to face.

Access and flow

- There were a significant number of medical patients on non-specialty or non-medical wards. We were told that the trust were piloting a scheme on the Queen's Hospital site, which gave senior nurses the autonomy to identify their patients and take these from medical assessment to their wards. The approach was designed to also encourage lead nurses to discharge appropriate patients quickly. This process hadn't been rolled out to King George Hospital, but senior nurses told us they would welcome the approach.
- Patients referred for cardiology appointments were seen within seven days, which was better than most trusts in the country.
- One hundred and forty seven (1% of) inpatients were moved four or more times per admission between April and November 2014.
- The average length of stay in medical beds in 2013/14 was 3.2 days compared to an England average of 3.9 days.
- A multidisciplinary approach to discharging patients was adopted. The Joint Assessment Discharge Team included nurses and social workers and worked together with patients whose discharges were delayed. Staff told us that families and carers were also involved in the discharge planning of patients.
- All members of the multidisciplinary team attended the meeting where the aim was to discharge patients within seven days. For patients known to social services, appropriate discharge arrangements were taken that involved notifying social services that the patient was about to be discharged from hospital.
- There was a discharge lounge, where patients awaiting transport for discharge were transferred to in order to ease the pressure of beds on the wards. Patients usually arrived on the discharge lounge with their take-home medicines and all patients were collected by 8pm at the latest. Pharmacy staff were also available on the wards to provide medicines to patients on discharge and could be contacted quickly when not on the ward. No patients stayed on the discharge lounge overnight.
- Junior doctors told us that patients were sometimes delayed from being discharged from the wards (five to 24 hours) as a result of their lack of capacity to complete the medical paperwork more speedily. Patients were also sometimes delayed from being discharged due to lengthy delays in completion of the take-home medication by the pharmacy. As a result, patients who were fit and mobile were sometimes allowed to go home and return to pick up their medicines later.

Learning from complaints and concerns

- The trust had acknowledged that there was a delay in responding to complaints in medical wards and this was on its risk register. Divisions who were performing poorly on complaints handling (of which medical care was one) had been tasked with devising and action plan for how they would address their backlog.
- We observed that information and leaflets advising patients how to raise a concern or complaint was displayed in ward areas. We noted that information leaflets on Gentian Ward were neither easily accessible, nor clear. One relative told us they did know how to make a complaint and had done so in the past, however, one patient told us that they would not know how to raise a complaint.
- Staff told us that informal complaints from patients and relatives were dealt with at ward level. Formal complaints were handled by the Patient Advice and Liaison Service (PALS), or by the complaints team.
- Junior medical staff told us that they were unclear about the complaints procedure for patients.

Are medical care services well-led?

Requires improvement

There was no agreed clinical strategy which meant that the management of medical care services at the hospital were unable to effectively plan and deliver services in response to the needs of local people.

We found that there was a backlog of serious incidents that were overdue for investigation. This meant that the hospital were not responding and learning from serious incidents to protect patient safety and to mitigate the risk of the same serious incidents happening again.

Junior doctors told us that they felt "unsupported" and "overworked". Most ward-based staff told us that they were happy with their work and direct line management.

Medical care (including older people's care)

Staff told us that the chief executive and other members of the executive team held regular meetings for staff to attend and the general manager for medical wards visited the wards each day during the week.

Vision and strategy for this service

- The trust has a relatively new board with several new members of its executive team. A clinical strategy was published in December 2013, however, we were told by non-executive directors and others that the clinical strategy was on hold and needed to be reviewed and refreshed. This meant that there was no active clinical strategy which meant that the management of medical care services at the hospital were unable to effectively plan and deliver services in response to the needs of local people.
- Examples of measures quoted in the strategy and published on the trust's website include; move all emergency medicine and surgery to Queen's Hospital by mid 2015, maximise the use of King George Hospital for day case, short stay elective and diagnostic activity, place intermediate care and rehabilitation at King George Hospital and move critical care beds from King George Hospital supporting the strategy of complex inpatient activity at Queen's.
- None of these measures had been delivered or were on target to be delivered and there was no clear clinical strategy for King George Hospital at the time of our inspection. This was corroborated by our conversations with local leaders at the hospital.
- The trust's vision was prominently displayed. Some staff articulated the trust's vision to us but others particularly junior medical staff were unable to.

Governance, risk management and quality measurement

- We found that there was a backlog of serious incidents that were overdue for investigation by senior nurses. Senior nurses told us that there was no medical or governance lead input in to serious incidents requiring investigation. In addition, there was no evidence that learning had taken place and disseminated following investigation of incidents. This meant that the hospital were not responding and learning from serious incidents to protect patient safety and to mitigate the risk of the same serious incidents happening again.
- We saw agendas and minutes for clinical governance meetings for both acute medicine and care of the elderly wards. These occurred on a bimonthly basis and minutes confirmed that these were attended by staff from different disciplines, including doctors. Infection control, NICE guidelines, record keeping, delayed discharges and quality monitoring had all been discussed during meetings.
- There was a risk register for acute medicine and care of the elderly wards. Risks included a shortage of medical and nursing staff on some wards and one 'unsafe' ward (Ash Ward). The risk register stated that Ash Ward had become unsafe for patients. Risks included: high vacancy and retention problems, concerns regarding healthcare assistants manual handling training, negative attitudes of staff on the ward, a lack of incident reporting and a high number of outliers without specialist input in care. It was not specified when this was placed on the register, but its review date was in the past, dated 17 November 2014.
- There were a variety of senior nurses meetings and staff forums to enable staff to share good practice and discuss relevant issues.

Leadership of service

- Ward-based staff told us they would recognise the division's managers and trust board members.
- We were told that the senior leadership of the trust was "improving". The chief executive was visible and periodically worked as a porter and on the wards. Other executives were also visible and the director of finance carried out "secret shopping" visits to wards and departments.
- Staff told us that the chief executive and other members of the executive team held regular meetings for staff to attend and the general manager for medical wards visited the wards each day during the week.

Culture within the service

- We observed a general manager directly stating to junior doctors: "We need more discharges, the emergency department is heaving." The tone of the statement came across as undermining to the ward-based consultant and ward manager.
- Junior doctors told us that they felt "unsupported" and "overworked". They told us that they attended weekly endocrinology meetings, which provided a platform for them to discuss issues. However, they told us that, although they had raised issues that affected their work, they had experienced little change.

Medical care (including older people's care)

- Most ward-based staff told us that they were happy with their work and direct line management. One band 5 nurse told us that working on the ward was "brilliant" and that there was good support and teamwork amongst colleagues. A recently-qualified nurse told us that they received good preceptorship support from their preceptor and staff in the team were approachable. Other comments from nursing staff included, "We have a fantastic manager," and, "I feel appreciated." Two domestic staff told us that they enjoyed working on the ward and were generally treated as part of the team.
- One healthcare assistant on Ash Ward told us they did not always have the time to speak to patients if the ward was busy. They felt they could not always give the care they wanted to give, due to the high number of patients to staff and the high dependency levels of the patients. However, they said that there had been improvements in the past year and the team was now functioning more effectively than it had in the past. There was a particular problem on Ash Ward, with two healthcare assistants on long-term sickness and a further two on suspension.
- Staff retention for cardiology services was good.

Surgery

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

Information about the service

The hospital provides a range of elective and emergency surgical services to the local population. These include: orthopaedic, breast and endocrine, general surgery including colorectal, urology and ophthalmology. Sixty-two per cent of operations are day cases. 18% are in-patient elective and 20% emergency cases.

There are five main theatres and two day case theatres, one of which was ophthalmic. Surgical patients were accommodated in three wards and the surgery day case ward. There was not a dedicated emergency theatre.

We spoke with 12 patients and five relatives. We observed care and looked at fifteen care records. We spoke with 25 staff that included: porters, ward clerks, admission administration staff, a multidisciplinary team coordinator, a theatre manager, ward nurses and managers, junior and senior doctors, Allied Health Professionals, community nurses and senior trust managers.

Summary of findings

There was a backlog in investigating serious incidents and, at the time of our inspection, 12 were over the 45 day target. The trust was taking positive action to investigate these.

Access and flow issues, such as theatre cancellations, bed management and supporting discharge were generally well managed. However, there was a referral-to-treatment backlog at the trust, which meant the trust was breaching national targets for these. The trust leadership was focused on addressing key risks to the service: reducing the backlog to outpatient appointments, improving referral-to-treatment times for surgery, and improving the IT infrastructure. We found a governance structure in place that provided leadership, quality checking and improvement. Many members of staff made comments on the improvements to the culture of the service.

We found good cleanliness, infection control and hygiene practices in place. Appropriate arrangements were in place for recording the administration of medicines. We found good evidence to demonstrate the trust's adherence to evidence-based care and treatment. However, some audits had been abandoned and others had not been completed to the expected deadline.

Patients received effective pain relief through ongoing monitoring and specialist support. Nutrition and hydration needs were being appropriately assessed and

monitored. Patient care was supported by competent staff who received annual appraisals. It was also supported by teams from a variety of disciplines. Patients and relatives we spoke with were happy with the care and treatment they had received.

We observed positive and respectful interactions between patients and staff. We found that patients' individual care needs were being met and quality of care audits monitored that care met individual patient need.

Are surgery services safe?

Requires improvement

There was a backlog in investigating serious incidents, and at the time of our inspection 12 were over the 45 day target. A senior sister had been seconded to chase this backlog and also work on new incidents. We found that a culture of reporting existed and that monthly incident statements were being fed back to teams and reviewed in team meetings. Risk was being appropriately assessed, recorded and responded to and there were adequate numbers of staff who were suitably trained.

There was good cleanliness, infection control and hygiene practice in place. Theatre checks, including ventilation, were carried out daily. Appropriate arrangements were in place for recording the administration of medicines.

Incidents

- As of 5 March 2015, 11 serious incidents (SIs) were being investigated relating to surgery at the trust. There was a backlog and an increasing trend in SIs and at the time of our inspection, 12 were over the 45 day target.
- A senior sister had been seconded to chase this backlog and also work on new incidents and new complaints processes going forward. This involved meeting with patients and relatives.
- Monthly incident statements were fed back to the wards. All incidents were rated by impact and risk and discussed in monthly ward meetings. In January 2015, there were eight incidents for Dahlia Ward. Four were for cancelled operations. Of the four cancellations, one was because a (ITU) bed was not available. The other three cancellations were due to patients cancelling for reasons of their own.
- On Erica Ward, an acute orthogeriatric ward, which admitted post operative fractured neck of femur patients, the incident report for January showed there had recently been a large number of falls on the ward. This was a high risk group because patients were often coming into hospital following a fall. The monthly ward meeting for February took place with the matron to address the high instances of falls. Measures were put in to place to reduce this number through actions such as use of bed rails, the allocation of low beds and moving patients at risk of falls closer to the nursing station. An

analysis of incidents also picked up that falls happened at night-time. Night staff were placed by bays for completing nursing documentation rather than at the desk. February's incident report stated there were only two falls for the month, greatly reducing the number of falls incidents.

- Incidents were processed on an electronic reporting system and provided a summary for staff, which was given in feedback at unit meetings and displayed on staff boards. Divisional governance meetings took place within the anaesthetic directorate as joint with Queen's Hospital on a monthly basis with matrons and sometimes with service leads.
- There was a communication board in theatres, which itemised the risk register and reported serious untoward incidents. There was a full log of incidents and actions next to the board.

Safety Thermometer

- The NHS Safety Thermometer measures a snapshot, once a month, of four areas of harm: falls, pressure ulcers, catheter-related urinary tract infections and venous thromboembolism (VTE). The national target is for 95% of patients to be free from these four areas of harm.
- Trust data showed that for the six months up to January 2015, the surgery wards were meeting the national target most of the time. However, in January, Heather Ward (colorectal, upper gastrointestinal bleeding or GI and urology) scored 89% and Iris Ward (urology) scored 93%, both due to old and new cases of VTE.
- Safety Thermometer measures were displayed and updated by ward staff. We saw that Safety Cross system boards were used to note staff shortages, if patients had fallen or incidences of pressure ulcers.
- The Safety Thermometer measurements were checked as part of their wider 'quality of care' audit. Where standards fell short, reviews were carried out by matrons and senior sisters to drive improvement.

Cleanliness, infection control and hygiene

- At our last inspection, we found improvements were needed in cleanliness and infection control and set a compliance action. At this inspection, we found improvements had been made.
- A number of infection, prevention and control (IPC) audits were carried out across the surgical division, which were broken down by ward and surgical area, such as theatre and endoscopy. The audits included hand hygiene, use of personal protective clothing, such as: aprons, safety spectacles and gloves, catheter insertion and asceptic technique. Monthly outcomes of these audits for 2014 showed a high level of compliance across surgery. For instance, hand hygiene audits for December 2014 showed 100% in all but two areas where they were 95%. Central venous catheter (CVC) and peripheral venous catheter (PVC) insertion showed the same level of compliance. Where audit outcomes were not 100% they were picked up through ward and unit meetings, where support for greater compliance was discussed.
- Daily cleaning checks took place on surgical wards. Checklists for cleaning the ward were signed daily.
- Hand wash stations and signs were located at strategic points on the wards. 'Fit to fly' – a daily checklist completed by the nurse in charge, checked items such as: 'hand gel bottles' were available, environment being clean and dust free, that all wrist bands were in place, controlled drugs were correct and that equipment was checked.
- In endoscopy, domestic support was available from 7am to 3pm. There were stickers in situ on commodes to mark they were clean. The department was clean with good signage and layout. All staff were trained in flexible scope cleaning and disinfecting.
- In their preassessment, all patients were swabbed for MRSA. Three clear swabs were required before surgery. On orthopaedic theatre and wards there was MRSA screening for all elective patients. In urology, we found MRSA figures were nil and all patients were swabbed.
- A clinical governance lead in theatres demonstrated audits for infection prevention and control, hand hygiene, cleaning were undertaken and that the World Health Organization (WHO) surgical safety checklist guidelines were fulfilled. This covered all key areas with signatures gained for completion. Where there were areas for improvement, key staff were contacted to action compliance. Daily and weekly checks were audited twice per month.
- We observed that theatres had been decluttered since our 2013 inspection and also now had a lockable IV fluids cupboard. Personal protective equipment was used and disposed of appropriately. There was safe specimen labelling and handling, as per trust policy.
- There was an MRSA screening for elective patients and three clear swabs were required before surgery. The

cases of infection for antibiotic-resistant bacteria, such as MRSA were within the expected range for a trust of this size. There was one case of MRSA and four cases of C. difficile reported by surgery services.

- Training figures for theatre staff showed that infection, prevention and control level 2 training was up to date for 60 of 67 members of staff. Infection control training for aseptic non-touch technique (ANTT) had been completed by 98% of staff. (ANTT is the standard intravenous technique used for the accessing of all venous-access devices and is the standard aseptic technique in the UK). In urology, all staff were trained in flexible-scope cleaning and disinfecting.
- A good standard of hand hygiene was observed in day case surgery. During our visit to the day case unit, two patients were found to have infected non-operation eyes, both were cancelled and given drops, as necessary, and their GP was informed.

Environment and Equipment

- At our last inspection, we found problems in the theatre environment – corridors were cluttered with equipment due to a lack of storage. At this inspection we found this problem had been resolved.
- There was a sterile services department on site, which fast-tracked equipment in five hours. Otherwise, there was a 36 to 48 hour turnaround. There was sufficient equipment available for most needs. Equipment was ordered through shared business services online and equipment came through within a week. In orthopaedics, we were told by surgeons that the loaning and availability of equipment was satisfactory.
- In endoscopy, we found that two fibre dryers for drying were kept clean and ready for use. Gastroscopes, colonoscopy equipment, flexis and bronchoscopes were all found to be in good working order.
- In theatres, capital investments were made to purchase three new operating tables and new laparoscopic stacking systems. Any request for new equipment went through a procurement process where the specialty in conjunction with the theatres service manager made a business case. The Theatre service manager sits as part of the procurement advisory group (PAG).
- Theatre checks, including ventilation, were carried out daily. Checklists for this were seen. Staff articulated what they would do for ventilation and temperature failure. There was a spare anaesthetic machine in recovery.
- There were two defibrillator trolleys. One was located in the theatre corridor and one in recovery. We checked the theatre corridor trolley and found it had missing items, which were in the anaesthetic room and we raised this with staff. In the endoscopy ward, we found a non-standardised resuscitation trolley that the surgical divisional lead was unaware of. They rectified this during our visit.
- We were told that urology had some facilities which could be used for emergencies, such as if washers or scopes failed.

Medicines

- We looked at the prescription and medicine administration records for ten out of 60 patients on three surgical wards. We saw that appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. The records showed people were getting their medicines when they needed them, reasons for not giving people their medicines were recorded. If people were allergic to any medicines this was recorded on their prescription chart.
- Most medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. However, on one of the surgical wards we found medicines, including intravenous fluids, were not locked away and could be accessible to unauthorised people.
- We saw controlled drugs were stored and managed appropriately. Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them
- A pharmacist visited all the surgical wards each day, including weekends. We saw that pharmacy staff checked that the medicines patients' were taking when they were admitted were correct and that records were up to date. Pharmacy staff were also available on the wards to provide medicines to patients on discharge and could be contacted quickly when not on the ward.

Surgery

Records

- On surgical wards, we found that nursing documentation in patient files had been well maintained. Records included: patient handling, mouthcare, continence, catheter, falls, bedrail, wound management, MRSA screens, weekly pressure sores scoring, Body Maps, malnutrition universal screening tool (MUST), weights, fluid and nutrition. Observation charts measured early warning scores (EWS) and monitored escalation, these scores were calculated daily.
- Comfort rounds were recorded every two hours and checked on patients' comfort, pain, drink, buzzer positioning and staff asked patients if there was "anything else I can help you with?" Daily communication records were also well maintained.
- Where it was appropriate, patients had the 'pathway for nutrition' documentation, which recorded food and fluid intake in detail.
- Cannula, pressure sores, patch and falls risk assessments were recorded.
- There were checklists for ward transfers. A 'checklist prior to notes going to ward' included checks on: x rays checked, blood results, Echocardiograms, MRSA and blood tests on day of admission. Medical files demonstrated that records were also well maintained. We found good examples of records such as "preop[erative] marking verification checklist" being completed, which stated the responsibility of the operating surgeon, ward staff, theatre staff. A "cannula assessment record" recorded gauge, consent (in tick box form) insertion reason (IVI) adhered to (asceptic technique, skin prep) and dressing type (Tegaderm).
- Quality of care audits were completed weekly by a senior nurse, with a different theme each week. Nursing documentation was regularly checked as part of this process. Where scores were not 100%, this was picked up in ward meetings, where staff looked at what could be improved on.
- A nursing documentation audit for January 2015 measured ten quality standards, including: all name and contact details, all risk assessments completed, pathways identified, clear records and fluid charts completed correctly. Most scores for the surgery wards and theatres were consistently high and were mostly 100%. Heather Ward had scored low on ensuring that daily patient assessments had been completed at least once every 24 hours and that pathways had been identified (60%).
- In surgical preassessment, preoperative assessments were undertaken and recorded prior and during consultations, and before the day of the procedure. The assessment was valid for a maximum of three months in case procedures were delayed or cancelled.
- Orthopaedic surgeons told us that there was a good availability of patient notes on surgical wards and for elective surgery, although, with emergencies, this was a little more difficult. The service in urology had a 4% rate of non-available notes.

Safeguarding

- There was a referral process for making safeguarding referrals. Staff we spoke with were knowledgeable about the safeguarding referral process. Staff gave us examples in which they had called the trust's safeguarding team for advice and instances where referrals had been made. Staff also told us they found the trust's safeguarding team to be a useful resource, who were helpful and supportive.
- Safeguarding adults level 2 and safeguarding children level 2 training had been completed by all ward staff.
- An orthopaedic doctor told us they received safeguarding training on induction plus a two-hour face-to-face teaching session.

Mandatory Training

- Mandatory training covered a variety of subjects, including: infection, prevention and control, moving and handling, resuscitation level 2 for both basic life support and paediatric life support, equality, diversity and human rights and sepsis awareness. Training in theatres also included intermediate life support for anaesthetic staff.
- Advanced life support training took place for all medical staff. Medical staff told us that study leave was not granted to them unless their mandatory training was up to date, so this was an incentive to ensure that their training was up to date.
- Training figures showed that staff were up to date with a large majority of these courses. Where training figures showed staff members were not up to date, it was demonstrated that they were either on maternity or sick leave or had courses booked.

Surgery

Assessing and responding to risk

- Since our last inspection, there had been a programme to improve understanding of sepsis and all staff we spoke with were aware of the sepsis protocol.
- The surgical wards used the national early warning score (NEWS) system for standardising the assessment of acute illness severity. We found that documentation was fully completed. Completed charts demonstrated that staff had escalated correctly, and repeat observations were taken within necessary timeframes. NEWS audits took place as part of the 'quality of care' audit process. The most recent audits we saw showed a 100% score for outcome, scores correctly calculated and cases appropriately escalated.
- In recovery there had been 13 patients moved to ITU since 1 February 2015. Nine of these were postoperative, but four were not. There was a bay reserved for major surgery and ventilated patients, so patient flow was managed.
- The NEWS was used in recovery and staff said they could access medical input when it was required. Nursing staff told us they always received 'excellent' support from anaesthetists.
- We found examples where risk assessments had been completed for individual treatments. For instance, we found risk assessments for the introduction of ENTONOX (gas and air). Anaesthetic record cards showed assessment with risks and medications stated. Operation records stated postoperation findings. Preoperative information recorded temperature, blood pressure, pressure sore scores, pulse, VTE scores and oxygen saturation.
- Patient records stated assessments on return from operation, such as 'patient comfortable' and 'observations taken'. It also stated plans in place, such as 'IV antibiotic'.
- In ophthalmic surgery on the day case unit, if patients were unfit to return home a hospital bed was found on site.
- In the day case unit, the WHO surgical safety checklist was observed as being in use at the ophthalmic surgery day case ward. All staff used the word 'DELTA' as a code, if they had any concerns, at which time, all activity stopped until the concern was resolved. This was an additional safety aid to ensure staff participation in expressing any concerns.
- Quality of care audits were completed weekly by a senior nurse, with a different theme each week. Recent themes had been falls and wristbands, Safety Thermometer, nursing documentation and the use of NEWS. What did not score 100% was picked up in weekly ward meetings, where staff looked at what could be improved on.

Use of the 'five steps to safer surgery'

- A trust steering group had been meeting to improve adherence to the 'five steps to safer surgery' (a pre-list team brief, an adaptation of some of the steps in the World Health Organisation – WHO – surgical safety checklist and the post-list team debrief). The new checklist required signatures from consultants. One hundred WHO checklist forms were audited each month. The outcomes of these were communicated to teams through unit staff meetings, where individuals were targeted to improve their practice.
- A clinical governance lead in theatres demonstrated audits for the WHO surgical safety checklist. This covered all key areas, with signatures gained for completion. Where there were areas for improvement key staff were contacted to action compliance. Daily and weekly checks were audited twice per month.
- We observed patient check in in theatre 5, which was completed by a competency-based trained HCA.
- We observed sign in, time out and sign out from an earlier case, which had all been carried out. At the time out on the first patient on the list for theatre 5, however, we observed that senior house officers (SHOs) and 'staff grade' staff did not participate in the time out because they were scrubbing up and not able to follow proceedings. In theatres, we found there was no record being kept of briefs and debriefs.

Nursing and theatre staffing

- Across the surgical wards, we found appropriate nursing staffing levels and low dependency on bank and agency staff. Some senior band 7 sisters were supernumerary. Investment had been secured to fulfil this and make all senior sisters supernumerary. This was confirmed by senior sisters we spoke with.
- Heather Ward had a full establishment of staff. On Erica Ward there were three nursing vacancies out of an establishment of 13. There was one healthcare assistant (HCA) vacancy. Regular bank staff filled vacant shifts. There were three instances of non-filled nursing shifts in

January, which were not filled by bank or agency staff. The senior sister told us this had occurred where there was very short, or no notice, of the vacancy and a decision was taken to carry on without.

- Dahlia Ward had three nurses and two HCAs on both early and late shifts on weekdays. Weekend shifts had been increased to the same level, due to weekend operations taking place. The ward was down by two band 5 nurses. The ward manager told us they were usually able to fill vacant shifts with Dahlia Ward staff doing bank shifts and sometimes from other surgical wards. Last year, they used an estimated 10-15 agency shifts.
- Senior band 7 sisters told us they felt they had enough staff. However, Friday late and night shifts could be pressure points because the number of operations carried out at this time had increased. These were all hip and knee operations, so they involved epidural and patient controlled analgesia (PCA) morphine pumps. This meant more tasks for ward staff.
- There was enough appropriately skilled staff to provide care to endoscopy patients.
- In pre-assessment, there were four nurses including one senior nurse to cover breast, general, orthopaedic, colorectal and urology clinics. There were two nurses on at any given time and cross working with Queen's Hospital happened, when required. There were usually 13 patients per caseload, per day and approximately 30 minutes per appointment.
- In surgery, both the anaesthetic and scrub teams were now totally staffed. There was one band 7 specialist nurse per theatre who was permanent, and not rotational. Band 6 nurses had the option of moving between specialties. There was a low rate of turnover in theatres. Turnover occurred last year only due to retirement and promotion.
- In day case surgery, there were eighteen beds and an average of ten contingency beds per night. In terms of staffing contingency beds in the day case unit, once the regular day case shift ends at 9pm, there was one trained nurse and one HCA who was on shift between 8:30pm until 7:30am to look after 10 patients. If there was more than 10 patients overnight, then there is an increase to two trained nurses and one HCA. Contingency beds took two nurses and one HCA seven days per week so the unit staffed these beds with bank staff. The unit was always staffed for ten patients even if less patients were in overnight.
- In theatres, staffing was as per nationally recommended standards from the Association for Perioperative Practice (AfPP) and there was no use of agency or bank staff.

Surgical and Medical staffing

- Surgeons had to cover their routine elective surgery lists in conjunction with managing the emergency surgery list. Surgeons told us they had tried to negotiate with the trust to enable consultants to be released from elective lists to fulfil the emergency surgery rota demand, but this was declined. We were told there were not enough surgeons to cover this and there was a pressure to clear a backlog of elective surgery waiting lists. There were plans to recruit a consultant to lead and manage the emergency lists.
- There were twelve orthopaedic surgeons running 26 lists per week. There was an on-site consultant providing on-call cover for trauma and another for electives.
- The current urology establishment was six consultants, but there were only five in post at the time of the inspection. At night, consultants in urology were on call for advice and got called, on average, twice a week to come in. There was a middle-grade registrar and junior doctor on site. Doctors felt there was a good liaison with other specialties.
- The surgical wards had junior doctor medical support, working from 8am to 6pm supported by a registrar who did ward rounds. We were told this was going to change to 8am to 8pm cover from April 2015. Consultants saw all patients prior to surgery and there was medical input from care of the elderly if required, after operating.
- In the pre-assessment, two anaesthetists covered duty each week to review notes and recall patients for a face-to-face appointment if they were deemed to be 'high risk'. There was an agreement to see any anaesthetist patient on the operating consultant's behalf.

Major incident awareness and training

- Senior ward sisters told us they had no knowledge of this, apart for being aware that ED would use their beds if the hospital was on alert. The elective nature of the service made this possible. However, the trust's surgical divisional lead told us that major incident training was mandatory for all grades down to band 7 and that induction also included major incident training.

Surgery

- Senior staff had all completed 'gold command' training. All on-call seniors would be required to come in during a major incident. We were given an example of the last 'standby' incident and how the debrief identified how to use walkie-talkies as a learning point.

Are surgery services effective?

Good

We found good evidence to demonstrate the trust's adherence to evidence-based care and treatment. However, some audits had been abandoned and others had not been completed to the expected deadline.

Patients received effective pain relief through ongoing monitoring and specialist support. Nutrition and hydration needs were being appropriately assessed and monitored. Patient care was supported by competent staff, who received annual appraisals. It was also supported by teams from a variety of disciplines.

Operations were occurring seven days a week and there was generally sufficient staff on duty to support this.

Evidence-based care and treatment

- Clinical staff had access to National Institute for Health and Care Excellence (NICE) guidelines and standards set by the Royal Colleges and other professional associations.
- The trust is a regional centre for the diagnosis and treatment of upper gastrointestinal and colorectal cancer. The service submitted good quality data to the National Oesophago-Gastric Cancer Audit, with the exception of records with a matched pathology record.
- Results from the National Bowel Cancer Audit in 2013 showed that data collection for patients having surgery was incomplete and the number of cases having major surgery was not recorded in the audit. Only half the patients were seen by a clinical nurse specialist, which was significantly worse than the national figure of 88%.
- The ophthalmology service had introduced toolkits to promote compliance with standards, such as those for the treatment of glaucoma. The ophthalmology diabetic screening service was delivered in line with quality assurance standards.
- There were enhanced recovery pathways for trauma and orthopaedic, neurology, colorectal, upper gastrointestinal and vascular surgery patients, overseen by clinical nurse specialists. The nurses audited the pathways.
- Surgical services submitted data to national enquiries. Anaesthetists contributed data to the Royal College of Anaesthetists' National Audit Project. There was also a local programme of approved audits to assess compliance with guidelines and good practice, such as preoperative testing and perioperative anticoagulation. However, some audits had been abandoned and others had not been completed to the expected deadlines. These included trust-wide surgical audits to monitor compliance with national guidelines for IV fluid and electrolytes management, and nutritional assessment in general surgical inpatients. An action point from a clinical governance meeting was to put in place a monthly review of approved audits to check progress.
- Trainee doctors told us of their involvement in service improvement projects using 'Plan, Do, Study, Act' cycles, in which improvements were planned, rapidly introduced and measured and the plan adapted to take account of the results.
- An 'evidence-based practice group' met on a bimonthly basis within the trust. Minutes from this meeting for June, August and October 2014 demonstrated that individual clinical leads took responsibility for specific evidence-based practice initiatives being reported to the group. Surgery items taken to the group during this period were a non-invasive surgical technique for rhinosinusitis and enhanced recovery programmes for colorectal surgery, hip and knee, radical cystectomy and hysterectomy.

Pain relief

- There was a pain management team who were based at the trust's other hospital site. A clinical nurse specialist from the team usually visited the surgical wards daily we were told, but not always. Ward staff told us they also called the on-call anaesthetist, who they found to be responsive.
- We observed the pain team nurse in recovery in main theatres introducing recovery staff to new paperwork. There were three nurses in the pain team who were available across the trust and they did not provide a weekend service.

- Comfort rounds were completed every two hours on surgical wards and staff checked on patients' comfort and pain management and what action had been taken in relation to these. Early warning scores also documented pain scores.
- We observed patients' pain scores were checked as part of routine rounding. Patients said they were well informed of progress and issues and felt pain was well managed.

Nutrition and hydration

- Patient's nutrition and hydration was being appropriately assessed and monitored on surgical wards through comfort rounds, which occurred every two hours and routinely monitored fluid intake. There was also a pathway for nutrition, which was used, when required, to monitor patients' food and fluid intake. The malnutrition universal screening tool (MUST) scores were monitored for all patients.
- On Dahlia Ward we found that, if patients were on a special diet, there was a nutrition board to assist in monitoring this and to raise the profile of their care. There were, on average, two to three patients on special diets at any one time, usually diabetic. The ward staff managed their own patients' nutritional needs.

Patient outcomes

- The National Hips Fracture Database Audit for 2014 showed the trust was better than the England average on a number of indicators: ascertainment rate, patients developing pressure ulcers, bone health assessment, falls assessment and mean length of post-acute stay. They were worse than the England average for surgery on the day or day after admission, preoperative assessment by a geriatrician and mean length of stay.
- The risk of readmissions for elective procedures was 102, compared to the national average score of 100, which was slightly worse. For urology it was 104, which was also slightly worse. For general surgery, it was the same as the national average. For non-elective surgery the trust scored better than the national average, at 94 with trauma and orthopaedics scoring 89.
- Patient Reported Outcome Measures (PROMS) were significantly worse for knee replacements than the English average and worse on some measures for hip replacement and groin hernia.
- The vascular surgery service had been consolidated and would soon be meeting expectations for a specialist service. An additional appointment of a sixth vascular consultant had been made, and there was an out-of-hours consultant service. The service had a clinical nurse specialist and a vascular laboratory to facilitate timely investigations. The appointment of two interventional vascular radiologists had increased the number of patients undergoing angioplasty, who previously would have had bypass surgery. However, the service did not have sufficient therapists to promote the enhanced recovery pathway at the time of the inspection. The service submitted data to the national vascular database that was independently verified.
- The trust submission to the National Emergency Laparotomy Audit for 2014 indicated that they provided many of the expected services, such as the availability of an operating theatre, the presence of a senior anaesthetist and surgeon when indicated and a defined pathway for patients. They did not have a policy of formal handovers. However, the service did not have sufficient staff to provide seven day a week therapy services.

Competent staff

- There was a system in place for appraising nursing staff. The band 7 staff appraised the band 6 staff and, together, they carried out the appraisals for the team. Ward staff were up to date with all appraisals with the exception of those on maternity or sick leave.
- 67 out of 70 appraisals were completed in theatres. In urology, only 1 of 21 medical appraisals was late.
- Induction and orientation was carried out over a period of a month. This was following a preceptorship course provided by the trust, which was six months long and involved meeting competencies specific to the role. We spoke with a newly qualified nurse who had returned after a student placement. They had a preceptorship and competency package, and told us everyone was always willing to help and got a good sense of teamwork.
- We were told that staff had extra learning opportunities available to them. For instance, a recent three-day course at the Royal Marsden Hospital on breast cancer was available. A homeodynamics course, run by the trust, had been completed by many nurses. Other extra courses had included: orthopaedic, diabetes and incontinence care. There was an allowance of courses

available for the wards to be able to attend. When courses became available, staff were asked to express an interest, and were then allocated a place on the course, up to the quota limit.
- For theatres there were mentorship, leadership and anaesthetic course places available at a nearby university for staff to attend on a day-release basis.
- There were link nurses for each ward who had a lead role in a particular topic, which included a dementia link nurse, who attended trust dementia meetings and training, then updated the ward on practice issues. There were also link nurses for diabetes, pain, infection control, tissue viability and nutrition. In theatres, there were link nurses for infection control, dementia, pharmacy and to ensure that the WHO surgical safety checklist was carried out. HCAs were also given the opportunity to act as link nurses.
- The day case ophthalmology service was transferred from Queen's Hospital in October 2014. Training for staff was still in progress for full competencies and rotation through other specialties.

Multidisciplinary working

- Patient care on surgical wards was supported by teams from a variety of disciplines. On Dahlia Ward, regular visitors to the ward included occupational therapists and physiotherapists, who attended morning meetings to help manage discharge and ensure care packages to support patient discharge were in place. There was also input from the pain team, dieticians, speech and language therapists (SALTs), anaesthetists and social workers when needed. The community orthopaedic project for Essex (COPE) team visited the ward two to three times a week and had daily telephone contact to support people post-hip and knee surgery and to provide community support.
- On Erica Ward, the Intensive Rehab Service (IRS), a team of physiotherapists, (provided by a neighbouring community foundation trust) assessed and engaged patients on the ward and supported them on discharge. We spoke with a hospital physiotherapist assistant who told us they liaised closely with the IRS and shared assessments. The IRS came to morning ward meetings and both IRS and hospital physiotherapy worked seven days. Heather Ward told us they also used IRS.
- On Heather Ward, we met with the care pathway facilitation team from North East London Foundation trust (NELFT). This was a community nursing team with access to community occupational therapists, who worked with wards to assist rehabilitation and assess suitability for community rehabilitation placements.
- There were multidisciplinary meetings every morning within orthopaedics, day case and surgical wards.
- For breast pre-assessment, Macmillan nurses were available on site and worked closely with the pre-assessment clinic.

Seven-day services

- There were seven-day services in theatres. Orthopaedic and general/urology both operated on a Saturdays and Sundays. Nurses had the choice of whether to work weekends, for which they were paid an enhanced rate. We were told there was not a shortage of uptake for this and the service found this worked well for them. Four additional band 5 nurses were given to the department to support this work.
- On Dahlia Ward there was a staffing increase at weekends to support operations taking place at weekends. Physiotherapists were available at weekends, but occupational therapists (OTs) were not. The ward experience of this was that OTs were available on call, but impacted on timely discharges as the ward was reliant on their assessments for equipment and discharge of hip and knee operation patients. The lack of OTs available on a weekend was recognised and had been raised with leaders.
- In endoscopy, there was an on-call rota. One on call nurse would be called in when needed to assist with the procedure which took place in the endoscopy unit. Being called in happened once a month on average. Nurses were on call one week in six or seven.
- There were no evening, early morning or Saturday clinics in pre-assessment.
- In orthopaedics, there were ward rounds from registrars at weekends.

Access to information

- Information in patient records on the wards was comprehensive and easy to read.
- There had been cases of delayed access to patient records, with the result that temporary records were created. There was a plan to address this, and the ward clerks we spoke with demonstrated how they made sure that all the records needed by medical and nursing staff were available. There was a tracking process for records.

- Some surgical specialties had introduced new handover processes for day to night and at weekends to improve the quality of information passed on to medical staff. An audit of the process in general surgery, which included a review of documentation and interviews with staff, had found that these processes were not always followed and had made suggestions for action.
- There had been recent investment in information technology (IT) to improve the recording of, and access to, patient information, including the introduction of a new electronic patient record system. The patient information stored was available to other systems. For example, the clinical patient management and handover system used by the trauma team, and the system to manage discharge.
- IT systems had been underfunded in the past and there was a strategy to improve and invest in the IT systems. The IT system for theatres was out of date and failed to provide the data required to manage the service. Administrators reviewed data manually in order to ensure that the data was accurate.
- We were told reliable patient data for use in management information and audits was available, but was time-consuming to access, and was derived from a number of sources.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Consent and capacity were assessed by doctors before treatment and procedures. If someone tried to leave the ward and were vulnerable, lacked capacity and were at risk of harm, then a Deprivation of Liberty Safeguards application was completed in conjunction with the safeguarding team and local authority. We were given examples of where patients were at risk of falls, or living with dementia, and where they had to have close, one-to-one observation due to their risk and, in these cases, a Deprivation of Liberty Safeguards had been put in place.
- There was no specific training for ward staff in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Only the wards' senior sisters had completed training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and recognising and understanding capacity. However, we were also told, and observed through speaking to staff, that they were knowledgeable about understanding what might constitute vulnerability, such as someone living with dementia or who lacked capacity to make decisions. Staff felt they worked as part of a team and, where patients appeared vulnerable due to capacity, they would escalate their case to senior sisters and to the safeguarding team.
- In preassessment, staff checked on patient knowledge and understanding of the informed consent they had given in outpatients. If they had any concerns, we were told they would contact the on-site clinical nurse specialist for the specialty and if they were not available and it was felt necessary, they would arrange another appointment with the consultant.
- Patient files showed a 'consent form 1', which detailed patient agreement to investigation and treatment. It stated explanation and risks to treatment had taken place. Forms we saw were completed appropriately and demonstrated discussion with patients and were signed by patients.
- We spoke with one patient who was waiting in preassessment, who told us they had completed a preassessment questionnaire and had consented in outpatients and fully understood the process.
- The trust's surgical divisional lead told us that staff had a heightened awareness of consent, capacity and Deprivation of Liberty Safeguards. They felt consent was 'variable' depending on the consultant seeking consent. With nurses, they felt they needed to do more about informed consent where there was a possible lack of capacity.

Are surgery services caring?

Good

Patients and relatives we spoke with were happy with the care and treatment they had received, and that a large majority of nursing staff were kind, respectful and friendly. We observed positive and respectful interactions between patients and staff.

Patients told us they felt involved in their care and had things explained to them regarding what to expect from procedures.

Compassionate care

- Overall, patients and relatives we spoke with were happy with the care and treatment they had received.

Surgery

- A patient on Dahlia Ward told us they felt well cared for by polite, friendly and effective staff. Another patient told us they were anxious about their operation and anaesthetic, but the anaesthetist spoke with her and helped to calm her anxiousness. She felt this was excellent care. The anaesthetist also came back to check on her a few times before the operation making her feel very well looked after.
- One patient on Heather Ward, told us they were very happy with the care they had received. They reported that staff were responsive to the buzzer and felt that staff treated them with dignity and respect. All of the staff we spoke with demonstrated caring attitudes. This included porters and HCAs.
- We spoke with the relative of a patient who did not speak English as their first language. The relative was happy to leave her mother and was confident of good, sensitive care and spoke highly of ward staff.
- In the day case unit, there were two curtained cubicles in a bay dedicated to ophthalmic surgery. We observed good empathetic interactions with staff. There was an area for accompanying relatives to wait. NHS Friends and Family Test scores were varied when set against the London average, which was 65. Iris Ward scored 97 and Dahlia Ward scored 80, better than the London average, whereas Heather and Erica Wards scored 38 and 58 respectively.

Patient understanding and involvement

- Overall, patients told us they understood and were involved in their care and treatment. A patient who was admitted as an emergency told us that the surgeons and anaesthetists explained procedures fully and had put them at ease.
- In ophthalmic day case surgery, we observed patients having procedures explained to them; what to expect, what is normal and what to do if they experienced pain.
- Another patient told us the operation was explained sufficiently during their preoperative assessment. They said they were assessed fully and were well informed.
- On Dahlia Ward, we spoke with a patient and their relative who had been on the ward for a while. They said ward staff, doctors and porters were all really helpful, kind and made them feel well treated. They also told us they felt well informed of progress and issues and were involved in their care.

Emotional support

- We were not informed of any specific counselling or support services available to patients regarding clinical care.
- We were told that chaplains did not do 'walkarounds' and only visited patients when requested.

Are surgery services responsive?

Requires improvement

There was a referral-to-treatment backlog at the trust, which meant the trust was breaching national targets

Side rooms on wards were made available to patients who, it was felt, were most in need of them. The trust had a dementia team, and healthcare assistants specifically trained in providing dementia care and managing challenging behaviour who worked shifts on wards with teams.

Patients' individual care needs were being met and quality of care audits monitored that care met individual patient need.

Access and flow issues, such as theatre cancellations, bed management and supporting discharge were generally well managed. However, there was a referral-to-treatment backlog at the trust, which was now 772 patients who were waiting over 18 weeks and ten waited over 52 weeks at the time of our visit.

Service planning and delivery to meet the needs of local people

- Side rooms were available on surgical wards for patients. We found examples where patients had been moved to side rooms based on need.
- In pre-assessment, there were four clinic rooms in use from 8.30am to 3.30pm. All slots were pre-booked and there was no 'one-stop shop' arrangement where patients could come directly from outpatients.
- Which hospital patients attended for their preoperative assessment was not based on their locality, but based on which of the trust's hospitals the allocated operating consultant was based at. Endoscopy patients, however, had a choice of hospital site for their procedure.

- The organisation of the post-surgery recovery compromised patients' privacy. Patients in recovery were moved to the far bays where they changed into clothing, which meant that relatives had to pass all post-surgery patients to reach this part of the unit.
- Language Line Solutions (a translation service) was available for translation and services, such as pre-assessment felt they received an excellent service from them. They tried not to use family and friends as interpreters on a principle of good practice. There were some information leaflets printed in common other languages. If this did not fulfil patient needs, we were told that PALS could provide further translator assistance. Dahlia Ward staff explained to us the three-way phone system to access interpreters. The ward staff told us that their experience of this was that it was accessible.
- Staff had an awareness and knowledge of the cultural needs and make up of their local population and told us commonly used languages were Lithuanian, Albanian and Urdu. The senior sister gave us examples of recently working in a culturally sensitive way with a patient's family that involved the ward maintaining contact with them overnight.
- On surgical wards, there was an information board located close to the ward entrance for patients and visitors. It included information on staffing, comfort rounds, meal times, trolley rounds for tea, magazines and sweets.
- The patients' waiting area before being seen in the anaesthetist's room was noisy and busy and had open views to recovery patients. However, we were told that recovery patients had been offered screens.
- On the day case unit, bays were designated as single sex the night before. Toilets were strategically located close by the bays and the male/female symbol on the toilet door could be flicked across, thus switched, to suit the gender of the bay. There were also a disabled toilet and shower. The bays closest to the nursing station were designated for inpatients who needed closer observation.
- There was an awareness of privacy and dignity and safe transfer of the anaesthetised patient within theatre.
- On the day case unit, there were two curtained cubicles in a bay dedicated to ophthalmic surgery, for privacy and dignity while administering eye drops. Patients were usually elderly and with poor sight and there was good patient assistance. For instance, staff would help these patients to operate the chair and offer them a blanket. We observed good empathetic interactions with staff. Signage to reception was highlighted in yellow to aid eye patients. There was a space for accompanying relatives and the environment was calm and peaceful. There were information leaflets detailing discharge medication, which was highlighted in a bright colour as a visual impairment aid.
- On the surgical wards, there were long visiting times from 10.30am to 7.30pm.

Access and flow

- There was a trust-wide referral-to-treatment (RTT) backlog, which came about from the transition from the old patient administration system (PAS) to the new one, which had led to the discovery of a possible 10,000 new patients since September 2014. The trust had worked to establish how many of these were 'real' patients and not erroneous system anomalies.
- The backlog was now 772 patients who were waiting over 18 weeks and 10 over 52 weeks (306 orthopaedics, eight maxillofacial, 152 ophthalmology, 11 gynaecology, 10 neurology, three dermatology, 164 general surgery, 13 pain). Some of these did have booked appointments, but the majority still did not. The agreement with the Clinical Commissioning Group (CCG) was to have less than 1,000 patients on the backlog by end of March 2015. The trust had a programme to address this issue and to meet the national waiting time target of 18 weeks for non-admitted pathways. A programme to address the long RTT times had been put in place and resulted in a reduction in the backlog of people waiting to be assessed and treated. Additional clinics and theatre sessions had been introduced and surgical, anaesthetic and theatre staff were working the additional theatre lists. There was work being done to reduce the number of late cancellations of clinic appointments and surgery.
- Ophthalmology had improved the inefficiencies of clinics, with fewer short notice cancellations of appointments, compared to up to 60% of appointments being cancelled at the beginning of 2014.
- The number of patients on the waiting list for orthopaedic surgery for over 18 weeks had been reduced to 171 in February 2015 and was on track to meet the target. Some surgery was outsourced to private hospitals and additional trauma lists had been created and staffed. Outsourcing was around 3,000 in total. In endoscopy, targets were being met. There were

waiting times of three weeks for two-week target and waits of six weeks for six-week targets. We were also told that issues of waiting times was exacerbated by increased weekend activity in outpatients.

- A review of theatre cancellations at the hospital for February 2015 was provided. This showed cancellations by specialty, the reason for cancelling and whether it was elective or non-elective. This showed a total of 56 cancelled operations, mostly in emergency and mostly because either the operation was no longer required or the patient was deemed unfit, with reason stated. Figures for theatre utilisation for February showed 87% for elective and 70% for emergency.
- On Dahlia Ward, incident reporting showed there was only one operation cancelled in January that could be attributed to the lack of an ITU bed. The review of theatre cancellations for February 2015 for the hospital showed two operations were cancelled due to lack of ITU/HDU bed in total.
- In recovery, there had been 13 patients moved to ITU since 1 February 2015. Nine of these were postoperative. There was a bay reserved for major surgery and for ventilated patients so rarely was there a flow issue. HDU and ITU were mostly referrals from urology Majors, which took place on Thursdays. There was a need to wait for the critical care consultant ward round for bed availability. Theatres tried not to cancel operations if this was possible, so would operate and book an ITU nurse to nurse the patient in recovery. If there were two ITU patients then only five of seven beds could be used. There were blockages that appeared when there was a fast turnover of lists.
- In recovery, at the time of observation, there were two patients ready for discharge to a hospital bed, but with no available beds. One patient was waiting fifty minutes for a bed on Heather Ward and one waiting for day case who was admitted that morning to MAU because there was no space on the day unit. Then there was no bed for them to return to.
- On Dahlia Ward, which was for elective orthopaedics, there was a fast turnover of patients. The ward manager told us there were as many as nine or ten admissions on a Friday and the target for hip and knee operations was a three to four day admission. The community orthopaedic project of Essex (COPE team) worked closely with the ward. There was daily contact and regular visits to facilitate discharge and community support. There was a 'day room' on the ward where new patients waited for a bed. There were four patients there at the time of our visit. Departures used the day room on the ward, which was also used for patients awaiting a bed to be ready.
- Erica Ward was originally a 20-bed ward, but had recently been increased to 23 beds after the day room had been converted into a three-bed bay.
- In endoscopy, there were two rooms with a capacity for 20 sessions per week, with ten slots per room, per session. There were 14 nurses registered to carry out endoscopic procedures for these twenty sessions, with 14 supporting nurses. There were eight inpatient slots per day, with two inpatient slots per session. A joint booking system (along with Queen's Hospital) showed all activity.
- In theatres, there was no format or overview of future scheduling across specialties. There was not a multidisciplinary team meeting to discuss the theatre list's content or equipment needs. Lists were sent to theatre two to four weeks in advance. If any additional nurses were needed to complete a list it would be granted on a 'first come, first served' basis. Once no more additional staff were available to cover, a request was made for the list to be amended. There was no 'lockdown' period, after which time no alterations or additions could be made.
- In endoscopy, there were two rooms with capacity for 20 sessions a week with ten slots per room, per session. There were 14 nurses registered to carry out endoscopic procedures for these twenty sessions, with 14 supporting nurses. There were eight inpatient slots per day, with two inpatient slots per session. A joint booking system (along with Queen's Hospital) showed all activity.
- In day case surgery, there were eighteen beds and an average of ten contingency beds per night. The night before our visit, for instance, there were seven. This caused flow issues the following day, as there were more beds required than beds available.
- The day unit would admit an average of twenty two patients per day, of which a maximum of five would be transferred to the ward as inpatients. This way bed capacity was managed.
- Patients were discharged directly from recovery. Nurses were trained to perform nurse-led discharges "by colleagues on the day unit".
- Urology ran from 9am to 7pm and saw 50 to 60 patients per day, including biopsies and treatments. They were

able to accommodate emergencies from the urology ward for things such as diagnostics. There were five theatres running two sessions per day: 8.30am to 12.30 and 1.30pm to 5.30pm.

Meeting people's individual needs

- There was no routine screening for dementia in a preoperative assessment. If there were concerns they would use the online toolkit and incorporate questions into conversations. If they had concerns after this, they would explain them to the family and carer and refer them to the trust's dementia lead. We were told that no patient has refused an offer of assistance.
- Dementia screening took place on the wards through an online assessment.
- A dementia care pathway was started, if appropriate, and specialist dementia nurses were used for support. There were also link nurses for dementia and training and they were also on hand for support. The trust had a dementia team and provided HCAs who had been trained in providing dementia care and in managing challenging behaviour. They worked shifts on wards with teams and gave ward HCAs on-the-job learning. The team were based at the trust's other hospital, Queen's Hospital. They also liaised with families as part of their role. Ward senior sisters felt this was a great resource and supported the wards well. On Erica Ward, the dementia team had run sessions on the ward on awareness, challenging behaviour, communication and the Butterfly Scheme. We were told the dementia link nurse went to all of the training provided and cascaded this to the ward staff. There was no mandatory training as such. We were told the most recent training by the dementia team took place in January.
- On Erica Ward, we found that when staff assessed that a patient might be living with dementia, there was a system for flagging this up on the handover sheet. This alerted the doctor to carry out an assessment. A magnetic symbol was then placed on patients' boards behind their beds to indicate this as an individual need with a blue butterfly. The Butterfly Scheme was in place to help identify and provide care to patients living with dementia. Care included involvement of the family and bringing 'home comforts' for people to aid familiarisation. We also found there was a dementia link nurse for the ward who attended trust dementia meetings and training and updated the ward on good practice issues.
- There were other symbols also used to indicate individual patient needs, such as for a visual or hearing impairment, for food monitoring, assisted eating, skin integrity, risk of falls and delirium.
- If a patient had a learning disability, it would be flagged up on the patient records system and patient Hospital Passports would be available. The senior sister for each ward would inform the trust lead for learning disability, who would work to establish what the support network for the person was.
- We met a patient with a learning disability on one surgical ward, who was with their parent. The patient told us they were very happy on this ward and referred to the nurses and doctor by name. They appeared to be very comfortable and at ease and were also able to tell us why they were on the ward and what was the next step in their treatment. The parent told us the ward had provided a safe environment and that they were confident that their daughter felt safe too.
- Documentation demonstrated the patients' individual care needs were being met. This included wound management, fluid and nutrition. Comfort rounds were every two hours and checked on comfort, pain, drink, buzzer positioning and whether the question 'is there anything else I can help you with?' had been asked.
- Quality of care audits ensured that care met individual patient needs and were completed weekly by a matron or band 7 nurse, with a different theme each week. Where scores were not 100%, this was picked up in weekly ward meetings, where staff looked at what could be improved. Audit scores were routinely scoring 100% or very near to.
- Surgical care pathway forms contained a section that required an answer; it stated: 'note any communication difficulties/physical or learning disabilities/mental health/medical condition, (e.g. pacemaker updating, interpreter requirement, custodial escort)'.
- On the day case unit, we found an example where a patient was known to mental health services and a frequent returner for undiagnosed physical health problems. The plan of action was to complete further tests on the day and refer to the liaison consultant psychiatrist if problems remained undetected.
- In breast surgery preassessment, Macmillan nurses were available on site and worked closely with the preassessment clinic.

- In preassessment, patients aged over 65 and those with preexisting cardiac conditions received routine Echocardiograms.
- We spoke to one patient on a surgical ward, who told us that they had been moved into a side room because of ongoing urological procedures and a bladder infection. Hence they were in a side room for greater access to the toilet.

Learning from complaints and concerns

- The trust reported 99 complaints received from 2014 to 2015 that related to surgery, up to January 2015. Sixty-one per cent had been responded to within the agreed timeframe. This was set against a trust target of 85%. Figures showed that response times had improved as the year had progressed. However, the trust had achieved its timeframe for responding to complaints for only one month so far over the year from 2014 to 2015.
- Theatre told us they had received one complaint in the last eight years and were not aware of complaints in other areas. Surgical wards told us that feedback from complaints was included in reports that were reviewed in monthly ward meetings.
- The surgical divisional lead told us that the trust's quality of care audit was owned by the surgery matrons. This meant that they were able to change the format depending on what they felt the live issues were, which included looking at complaints. We were given an example of where they recently heard that medications were being left out on a table.

Are surgery services well-led?

Good

The trust was focused on addressing the key risks to the service: reducing the backlog to outpatient appointments, improving referral-to-treatment times for surgery, and improving the IT infrastructure. There were trust-wide improvement measures in place to integrate the local risk management systems, to clear the backlog of serious incident investigations and to incorporate the Duty of Candour requirements into the incident reporting system.

We found a governance structure in place which provided leadership, quality checking and improvement. Many members of staff made comments on the improvements to the culture of the service. Staff said that the focus on patient care, begun by the previous chief executive, had produced tangible results.

Vision and strategy for this service

- At the time of our inspection, the trust was focusing on addressing the key risks to the service: reducing the backlog to outpatient appointments, improving referral-to-treatment times for surgery, and improving the IT infrastructure. Staff in surgical services were working with the trust in the concerted effort to address these risks. We heard of senior staff leading the team effort, and of frontline staff working hard to make the improvements required.
- There was some concern that other risks might be missed. A member of staff commented, "There's so much fire-fighting, they haven't got time to look at the smouldering in the corner." The leadership of the newly aligned divisions, however, was aware of the extent of the challenges and felt that, with the support of the trust executive, clinical staff were "willing and able" to meet them.
- The surgical divisional lead told us they aimed to strengthen clinical governance as part of their new role. The new surgery division will be specialist orthopaedic, ophthalmology, hips, knees and breast. The vision included allowing theatre and ward staff to rotate or have the option to work on both. The aim was to give staff better access to opportunities.

Governance, risk management and quality measurement

- There was awareness at trust board level, and among senior staff in the newly realigned divisions, of the immaturity of clinical governance processes and of the work needed to embed a systematic approach to risk. We found all the elements of a clinical governance system had been in place within the surgical services in the past, but these had been poorly supported because of insufficient staffing and inadequate IT systems. This resulted in a risk management process that was not integrated.
- There were trust-wide improvement measures in place to integrate the local risk management systems, to clear the backlog of serious incident investigations and to incorporate the Duty of Candour requirements into the incident reporting system. Governance facilitators were

appointed to the divisions in April 2014. These posts were being realigned with the new divisional structure. The facilitators in surgical services were developing a more systematic approach to the review of incidents and learning, and were sharing good practice to promote a common approach to clinical governance.

- The monthly management information for each specialty report included an outline of incidents, the number and types of risks on the register, response times to complaints received and responses within the time scale, a summary of legal claims and compliance with NICE guidance. The governance facilitators also tracked morbidity and mortality (M&M) meetings and audits. They produced department-specific alerts and information and identified themes for further discussion. A monthly summary of the departmental report was produced for the trust quality and safety committee.
- There were monthly specialty meetings to discuss governance, and some of these were arranged to allow staff to attend without other duties. Medical and surgical staff from some specialties were positive about the discussion and dissemination of learning at these meetings. However, not all lists were cancelled to allow for attendance, and this affected not only surgical and medical staff, but meant that anaesthetic and theatre staff would not be able to attend their divisional governance meetings. Wider learning outside specialties was limited. For example, changes were made to the way injections in ophthalmology were carried out following an incident, but this was not shared with dermatology services, who might have benefited from the learning.
- The surgical divisional lead told us the quality of care audit was owned by the surgery matrons and involved environment and quality of care. If some wards looked like they were struggling they would be supported to improve. The format of audit changed depending on what they felt were the live issues at the time. This was done by looking at complaints and incidents. For example, an issue that came up prior to the inspection with medication led to a medicines management audit.
- Quality of care audits were completed every Thursday by a matron or senior sister, with a different theme each week. We were told recent themes were: falls and wristbands, Safety Thermometer, nursing documentation and NEWS. What did not score 100% was picked up in weekly ward meetings and looked at what could be improved on.
- In January 2015, the quality of care audit monitored observation and national early warning scores (NEWS). This included whether observations and NEWS had been recorded in the previous twelve hours in line with NICE guidance CG50: Acutely-ill patients in hospital: Recognition of, and response to, acute illness in adults in hospital. It also measured the quality of the observations and whether NEWS had been calculated correctly and escalated when appropriate. Surgical wards and theatres had scored 100% in 23 out of 27 scores.
- The clinical governance lead in recovery in main theatres demonstrated audits for infection prevention and control, hand hygiene, cleaning and the WHO safety checklist. This was comprehensive and covered all key areas with signatures gained for completion. Where there were areas for improvement, key staff were contacted to action compliance. Daily and weekly checks were audited twice per month.
- Divisional governance meetings took place within the anaesthetic directorate jointly with Queen's Hospital on a monthly basis, with matrons and sometimes with service leads.
- Monthly audit meetings took place in theatres – these meetings also acted as training sessions for staff. A matron-led unit meeting included a review of incidents, trust documentation, feedback and suggestions.

Leadership of the service

- The divisional management structure of divisional manager, Divisional director and divisional nurse was viewed positively as a way of engaging clinicians in solving problems. These divisions had recently been reorganised at the time of our inspection and it was too soon to assess their effectiveness. There was recognition of the challenges, and how far there was to go to make the improvements needed to address immediate concerns and to plan for the future.
- We saw examples of effective leadership in the clinical areas we visited. Matrons kept ward staff informed of trust-wide developments, and sisters told us they felt well-supported if they needed advice. Good practice had been shared across several surgical wards when an internal assessment found variation in performance.

Nurses and healthcare assistants felt they could approach senior nursing staff if they had any clinical questions or other concerns. They also felt well supported in professional development, and rostering was flexible to meet the needs of staff with caring responsibilities. However, there was concern that because staff were so hard pressed, they were less likely to take up training opportunities. We were told of the cancellation of a training session organised by a consultant anaesthetist because theatre staff were rostered onto additional lists.

- Junior and middle-grade doctors training in surgical services were well supported. They said the trust had a good reputation for training in surgery.
- The trust's surgical divisional lead was new in post, but had worked within the trust for some time. There was a senior sister band 7 nurse in charge of each surgery ward, some of which were supernumerary with plans to make all supernumerary. Each ward had a matron with oversight of the service, usually based at the trust's other hospital: Queen's Hospital. For instance, for Dahlia Ward, an elective orthopaedics ward, the matron for orthopaedics, was based at Queen's Hospital and visited the hospital on Fridays.

Culture within the service

- Many members of staff made comments on the improvements to the culture of the service. Staff said that the focus on patient care, begun by the previous chief executive, had produced tangible results. Staff said they felt empowered to challenge each other. For example, by using the 'yellow card' to remind colleagues about the behaviour and values expected of staff. Many of the staff we spoke with, in groups or individually, said the current executive group were visible and there was an increase in confidence in problems being tackled.
- We found examples in surgical services of good teamwork and a positive approach to solving problems. Staff on the wards, in theatres, and in the surgical assessment unit and on the day care unit said that good team work enabled them to take on the challenges in their work. There was good communication between nursing, medical and surgical staff, and administrative staff were valued for their contribution.

Public and staff engagement

- There had been a number of initiatives to encourage patients and their families to provide feedback and to involve the local population in developments at the trust. One of the deputy chief nurses was responsible for coordinating this work.
- The Patient Advice and Liaison Service (PALS) had a visible and accessible office, with appropriate facilities to talk to people in private, and staff with communication skills in British Sign Language and some community languages. They were integrated into the work of the wards in addressing issues raised by patients at the earliest opportunity. The Improving Patient Experience Group, which included patients and members of the public, as well as the PALS, the patient experience facilitators and other trust staff, were chaired by the deputy chief nurse. Support groups, such as The Brain Tumour Charity, organised stalls in the foyer of the hospital to provide information to the public.
- We spoke with the patient experience facilitators and saw how their work to improve signs had made the hospital more welcoming and gave the public better access to information. An example of these were boards illustrating the different uniforms worn by hospital staff and signs encouraging patients and their families to use interpreters if they needed them. Boards in clinical areas provided an explanation of the service provided and had pictures and names of senior nursing staff. There were whiteboards on the wards and units showing the NHS Friends and Family Test scores, which also included comments gathered from patients and their relatives and a 'You said, we did' section noting what the ward had done in response. When there were themes in comments, such as food, this was explored further, in order to look at ways of making improvements.

Innovation, improvement and sustainability

- We saw examples of improvements to surgical services as a result of clinical engagement in meeting the nationally-agreed standards, and greater accountability for these standards. Ophthalmology, for example, was reviewing the cataract pathway to streamline the service and exploit the new theatre facility at King George Hospital. General surgery services had engaged local GPs and patients in an emergency surgical away-day, which had looked at national guidance, and the access and flow of patients. The Emergency Surgery Policy had

brought this information together to set out the improvements, including the changes to the way the surgical assessment unit at Queen's Hospital was located and staffed. There was multidisciplinary team engagement, with improvement work. For example, in the development of the vascular service at Queen's Hospital.

- Trainee doctors in surgical specialties said they were encouraged to contribute to improvements. When new consultants were appointed in general surgery, a first year trainee pointed out there was no increase in the number of junior doctors to do the additional work for consultants. Doctors' assistant posts were created, and had been assessed as being effective.
- Nevertheless, we were also told of frustration when improvements developed by clinical staff were delayed or cancelled by the trust. A revised WHO surgical safety checklist had been developed in theatres after consultation with staff. It had taken five months to complete before it was signed off, without any changes being made to the format. Neurology had piloted the use of rehabilitation beds, but this had been cancelled in spite of an audit finding improved outcomes for patients. Some staff felt that the focus on addressing the key risks resulted in innovation being neglected, in particular, if there was an initial cost to an initiative.
- There were concerns about whether the level of effort required to address the key risks would be unsustainable. Financial sustainability was also a concern: there had been an increase in theatre throughput by staffing additional lists, but this had not come from the central budget, so theatres were overspent. Furthermore, the population of the areas was increasing, but the trust was unable to meet current demand.

Critical care

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

Information about the service

The critical care unit, based on the first floor of King George Hospital, provides care for patients with a diverse range of medical and surgical conditions, with the exception of neurosurgical and paediatrics.

The intensive care (ICU) and high dependency units (HDUs) are specialist hospital wards. They provide intensive care, treatment and monitoring for people who are critically ill and deemed to be level 2 or level 3 dependent on level of organ support required.

The unit had the capability to support up to eight level 3 patients. It was usual for five level 3 patients and three level 2 patients to be admitted. However, the unit was able to adapt to the acuity of the patients with appropriate nursing support.

The hospital operated a critical care outreach service (CCOT) to support staff and patients on other wards in the hospital. They advised staff on caring for patients who required extra care while admitted to the general wards, or helped to identify patients who may be deteriorating and who required a higher level of support in HDU or ICU.

The critical care unit was led by a team of consultants. There was a multidisciplinary team of general ICU nurses, and physiotherapists. There was access to pharmacists, speech therapists and dieticians. The staff in the units were supported by healthcare assistants and administration staff.

Immediate family and friends could visit patients from 6am to 3pm and from 5pm to 9pm. There was a rest period for patients between 3pm and 5pm.

We spoke with a full range of staff that included: two consultants, one medical student, eight nursing staff of different grades, the senior nurse lead, four Allied Health Professionals (which included physiotherapy and pharmacy) and two support staff. We also heard the views of staff attending focus groups. We spoke with patients, their relatives and friends. We observed care and the environment. We reviewed patient records and hospital data, such as audits, policies and procedures.

Critical care

Summary of findings

Patients and relatives spoke highly of the care and treatment they received in the Intensive Treatment Unit and High Dependency Unit. They told us they were kept updated about their family member's progress using language they understood. Visitors to the ward were made to feel welcome and were encouraged to support their family member if they felt able to.

There were insufficient critical care beds available for the population served by the Barking, Havering and Redbridge University Hospitals NHS Trust in comparison with other London trusts. Capacity was high at an average of 95%. It was estimated that critical care bed shortages affected 100 to 200 patients across the trust each month, with patients experiencing cancellations of planned procedures and significant waits in A&E (or in the recovery unit) while waiting for ITU beds.

Changes in the acuity of patients and reduced staffing levels meant patients were not always supported on a one-to-one basis, as per national guidance. Despite the bed shortages and staffing levels, we saw that staff continually assessed the safety of the patients and only supported patients on the ward or in the recovery unit if it was staffed appropriately, ensuring the safety of the patients.

Staff were aware of how to support patients and their families' individual needs. Staff spoke passionately about providing the best care they could to achieve the best results for their patients. Patient outcomes and mortality rates were within expected ranges when compared to similar services.

Care and treatment was delivered by trained and experienced nursing staff. There was a clear reporting structure and staff told us they felt supported and confident in their role.

Temporary and newly-qualified staff had to achieve a set of core competencies prior to working with patients on an individual basis. Junior medical staff spoke positively of the support and learning they received from consultants.

There was little evidence of multidisciplinary team approach. Physiotherapists spoke with consultants and nurses daily about how to support patients, but access to other professionals was carried out on a referral basis.

All the governance meetings took place at Queen's Hospital and we found that the consultants did not have a strong grasp of governance, risks or concerns relating to the unit.

Most staff were not engaged with the trust's vision and were unaware of the senior lead's vision for critical care services. This was affecting morale, which the senior staff on the unit were managing.

The outreach team supported ward-based staff in the early identification of patients who were at risk of deteriorating and who may require an HDU or ITU bed. Critical Care Outreach Team (CCOT) also provided an outpatient clinic to support previous critical care patients in the months after their admission to ensure they continued to progress.

Critical care

Are critical care services safe?

Requires improvement

Care and treatment was delivered by trained and experienced staff. A dedicated consultant remained on the unit between 8am and 6pm. A senior trainee doctor remained on the unit with the support of an on-call consultant outside of these hours. Consultants worked on a week-by-week rota to promote consistency in care.

There were not always enough staff to support level 3 patients on a 1:1 basis and this could mean that nursing staff were required to support a level 3 and a level 2 patient, and, occasionally, support two level 3 patients. However, we saw continual efforts to ensure the patients benefitted from safe, quality care, treatment and support.

We saw that people's care needs were assessed, planned and delivered in a way that protected their rights and maintained their dignity. The care plans we reviewed demonstrated that care was risk assessed. Where a risk was identified, it was managed effectively and reflected the patient's needs and circumstances.

Guidance from the Intensive Care Society (ICS) advocates that all level 2 (L2) and level 3 (L3) patients should be cared for in a closed unit (i.e. in one area) and medical oversight of the unit should be by intensive care physicians. The hospital achieved this, however, there were occasions when patients had to be cared for by appropriately qualified staff in the recovery area until a bed became available on the unit, or they could be safely transferred to Queen's Hospital. The care of these outlying patients came under the intensive care consultants and nurses.

Staff felt confident to raise incidents or seek advice from a member of senior staff. We found that incidents were investigated and an outcome was recorded. We noted staff were informed of any changes or reminded of procedures through one-to-one conversation, team meetings and in writing.

There was an ample supply of equipment and medical supplies to meet patient needs. Equipment was cleaned in line with the trust's infection policy. Regular hygiene audits were performed. Staff were seen to use personal protective equipment and follow hand hygiene protocols.

Incidents

- Staff were encouraged and supported to report any incidents as they occurred using the hospital's electronic incident reporting system. Staff we spoke with described how they could report incidents and all staff said they felt confident to raise their concerns with the senior sister.
- We reviewed 30 incidents reported between August and December 2014. Reportable incidents included, amongst others: medications errors, pressure ulcers and staff shortages. All the incidents had been reviewed and an outcome had been documented. We noted if the incident related to poor practice or a change in procedure, the record indicated staff had been reminded or informed of procedures.
- We were unclear as to whether or not all staff shortfalls on the unit were routinely reported, as the number of incidents was low compared to the staffing levels described. We noted eight of the 30 incidents we reviewed related to staff shortfalls affecting the safety of patients. The shortages required staff to double up patients who may have required one-to-one care, as per national guidelines. We noted the rationale as to which patients were doubled up was not included, therefore, the staff's risk assessment and reasoning was not recorded.
- Staff reported there had been no pressure ulcers for the 12 months prior to the inspection. However, when we reviewed the incident folder we noted a pressure sore was reported on the 21 January 2015 and 24 February 2015. This was discussed with the senior sister who told us they had not been classed as incidents. There was some written evidence of a root cause analysis (RCA), but it was unclear how it had been disseminated to the team.
- Incidents and complaints were reviewed and discussed at the consultant's meeting.

Safety Thermometer

- A Safety Thermometer (an improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care) was produced for the critical care unit. This information related to hospital mortality, audits for discharge, hospital-acquired infections and the quality indicator dashboard. Information was displayed for staff

or visitors to the ward to see how well they were performing. Information provided by the trust below showed that King George Hospital scored 100% for the last four months of 2014.

Cleanliness, infection control and hygiene

- The Intensive Care National Audit & Research Centre (ICNARC) 2015 data showed there were no concerns at King George Hospital ITU in relation to hospital-acquired infections, such as MRSA or C. difficile. The unit and scored better than its comparator for patients who acquired MRSA at less than 0.5 infections per 1,000 patient days.
- ICNARC 2015 data showed that no patients had acquired a blood infection while admitted to the unit.
- We noted that the environment appeared to be clean and tidy. The nursing staff were responsible for the weekend cleaning programme, which included all surfaces, the sluice and equipment located in the room, such as the blood gas machine, bedpans, commodes and the thorough cleaning of the nurses' station. Nursing staff signed to say they had completed the weekend cleaning schedule.
- We spoke with the nurse for infection prevention and control (IP&C). They told us they performed an environmental audit twice a year. This included checking the cleanliness of high and low areas and the sluice room. The report fed into the matron's senior sister meetings.
- The link nurse described the MRSA protocol, which defined how patients identified with an infection were treated and monitored. If a side room was not available and the infection was not symptomatic, patients could be treated within a bay area.
- The ward link nurse for IP&C was responsible for performing various weekly and monthly audits, such as hand hygiene, commodes and sharps protocols. Any concerns were raised with staff and regular offenders' performance was monitored. The common themes related to dust on surfaces, visitors' bags positioned on the floor, or beds and spillages on the blood gas machine.
- We observed staff following hand hygiene protocol. Signage was used to remind staff and visitors about hygiene measures when providing care, or visiting patients with infections.
- A clinical waste and general waste bin was available within every bed space.
- Sharps bins, hand gels and personal protective equipment (PPE) was available at every bed space. We observed staff decontaminating their hands between patient contact and using PPE, such as gloves and aprons. These were removed and replaced when moving between different patients.
- Hand washing facilities were not available at every bed space, however, they were available within the unit. We noted that the basins, taps and soap dispenser were clean.
- We found some small spots of blood on the blood gas machine.
- All the commodes, which included the seat and frames, were clean and unmarked, including the underside of the seat.
- There was an area available for visitors to the unit to hang their coats outside the ward area.

Environment and equipment

- The unit was made up of a ward with five bed spaces and two side rooms. One side room accommodated one patient and the other side room accommodated two patients.
- All equipment was owned and maintained by the trust. It was seen as all the staff members' responsibility to report any broken or missing equipment. Staff told us they had no issues with maintenance or availability of equipment. Occasionally, the unit borrowed from, or lent, equipment to the critical care units at Queen's Hospital.
- We noted the beds were modern and appropriate for the critical care unit. Each bed space had pendant mounted monitoring and ventilation. Additional equipment was generally securely mounted.
- Resuscitation equipment was available. The content of the trolleys was checked every day and we saw records supporting these checks. The checks were audited every six to eight weeks to ensure the records were completed correctly.
- Emergency/difficult intubation equipment was available and staff were aware of its location in the event of an emergency. Emergency tracheostomy equipment was readily available next to the tracheostomy patients' bedsides.
- Visitors gained access to the units via a buzzer and intercom system. Visitors to the General Intensive Care Unit (GICU) were buzzed in through the door into a 'hallway' area where the sister's office and visitors room

was located. Staff were unable to see who they were letting in until the person had entered the ward area. This could cause some difficulty if the person visiting had a disability and was unable to open the door, or was an unwelcome visitor and was known to cause problems on the ward.
- The visitors' room was small, but adequate for the number of visitors usually attending the unit. Tea and coffee facilities were available.

Medicines

- Staff had the relevant competencies to carry out IV drug administration. Agency/temporary staff competency was checked and signed off by the senior nurse in charge.
- Staff followed the protocol for all controlled drugs to be signed for by the nurse drawing up the drug, and by a colleague who witnessed the correct drugs had been drawn up against the prescription.
- A new style pre-printed prescription chart called 'Continuous Intravenous Infusion Prescription Chart' had been devised by the consultants in the neuro-intensive therapy unit at Queen's Hospital. This was to minimise errors by standardising the prescriptions and to aid repeat prescription. The consultant did not need to write out drug names each time they prescribed it and were only required to sign and date against the drug required on the pre-printed chart. The critical care unit at King George Hospital had been asked to trial it. However, the senior sister had refused, as it was not specific to them. For example, Queen's Hospital used Addiphos®, which was included on the pre-printed chart and King George Hospital used Phosphates Polyfusor®, which was not included on the pre-printed chart.
- The unit held its own supply of commonly-used drugs, which were checked and updated for relevance by a pharmacist on a regular basis. Medicines on the unit were securely stored.
- Medication administration records (MAR) we reviewed adhered to the national prescribing guidelines and were recorded appropriately.
- The unit had devised safety measures for the haemofiltration fluids used during continuous renal replacement therapy. They had devised a sticker, which was stuck onto the nursing note charts to show the prescribing doctor's signature, the initials of the nurse putting up the fluid and the nurse who witnessed.
- A pharmacist visited the unit every week day.

Records

- Records were securely stored in a way that promoted confidentiality. All patient records were located in the nurse desk at the end of each patient's bed. Records were taken with the patient when they were discharged from the ward.
- Bedside notes and charts were up-to-date and organised in chronological order.
- We found that patient records included a daily summary and treatment plan completed by the consultant. This included clinical assessments, impressions, care bundles and a care pathway.
- Records included risk assessments, such as pressure ulcer risk factors and the use of mittens for patients who were at risk of pulling out tubes and causing injury to themselves**.**
- We were told by staff that patient records did not always arrive with the patient when they were admitted to the unit. This was usually for patients admitted via A&E. Staff reported that medical records provided an efficient service when patients' previous notes were required. One member of staff said, "They are brilliant, very responsive if we need them urgently."

Safeguarding

- The staff we talked with demonstrated a good understanding of what safeguarding vulnerable adults and children meant in practice and were able to describe how to escalate any safeguarding concern. They were aware of how to contact the trust's safeguarding link nurse.
- The safeguarding policy and procedure was available on the hospital's intranet, however, we found there were two policies available, one of which was out of date and was due for review in December 2011, over three years prior to our inspection.

Mandatory training

- The trust's target was for 80% of staff to have completed mandatory training. Records showed this had been achieved by critical care staff in every module apart from conflict resolution, which was close to the target at 74% compliance and PRIDE (the trust's values), which was at 63% .

Assessing and responding to patient risk

- The Richmond Agitation Sedation Scale (RASS) was used to measure agitation of sedation levels of a patient. It was mostly used in mechanically-ventilated patients in order to avoid over and under-sedation.
- National early warning scores (NEWS) were completed on patients prior to their being discharged to the ward.
- Patients were monitored for different risk indicators. Each ventilated patient was monitored using capnography, which monitors carbon dioxide in respiratory gases. It was available at each bed on the unit, and was always used for patients during intubation, ventilation and weaning, transfers and tracheostomy insertions.
- Delirium assessments were in the template for nursing records. Delirium is an acute, fluctuating change in mental status, with inattention, disorganised thinking, and altered levels of consciousness. It is a potentially life-threatening disorder characterised by high morbidity and mortality. Delirium is common in intensive care patients, especially among mechanically-ventilated patients. In critically-ill patients it is associated with an increased length of stay and increased mortality.
- Staff identified areas on patients' bodies that were more susceptible to getting pressure ulcers, such as where nasogastric tubes touched the face and ears. As soon as any redness in the skin was identified staff protected the areas to ensure they did not become ulcerated.

Nursing staffing

- The unit was overseen by a matron based at Queen's Hospital.
- A senior sister was responsible for the day-to-day running of the critical care unit at King George Hospital.
- The Intensive Care Society core standards for intensive care units states that all ventilated patients at level 3 are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and all level 2 patients should have 1:2 care.
- There were not always enough staff to support level 3 patients on a 1:1 basis and this could mean that nursing staff were required to support a level 3 and a level 2 patient, and, occasionally, support two level 3 patients.
- The unit had 31 nursing staff plus three who were currently on maternity leave. There were seven nurses on duty for each 12-hour shift. The senior sister was on duty during the day from Monday to Friday. We were told there used to be eight nurses allocated to each shift, which meant there was rarely the need to double up patients inappropriately. However, staff numbers had been reduced and it meant patients who required one-to-one care could be doubled up more frequently.
- Despite the staff shortage, we saw continual efforts to ensure the patients were receiving the support they required safely. For example, the senior staff assessed the stability of the patients, whether there were any infections that could easily be transmitted if a staff member was nursing two patients, and the location of the patient in the unit. It would be harder for a member of staff to nurse two patients who were not situated in beds next to one another.
- Once the patients' needs were assessed, senior staff decided which nursing staff had the skills and experience to support two patients at the same time. Only experienced staff were asked to support another patient when they were already caring for a level 3 patient. The senior charge nurse explained they would feel comfortable asking an experienced member of staff (substantive or regular agency) to care for a stable ventilated level 3 patient and a level 2 patient. Staff were able to refuse to work in this way if they felt it was unsafe or inappropriate care.
- The critical care outreach team (CCOT) based at Queen's Hospital had 11 band 7 nurses, three of which worked on a part-time basis. The CCOT provided one nurse at King George Hospital between the hours of 7.45am and 8.15pm on a rotation basis.
- Staff absences were covered by regular in-house bank staff or agency staff. Occasionally, staff from Queen's Hospital were asked to cover absences. Staff told us the use of agency staffing was low, at 13% for the previous year.
- If extra support was urgently required, a member of the outreach team could support GICU/HDU until agency staff could be sought. However, this would mean the outreach team was suspended to support staff and patients in another part of the hospital. We saw this in action on the last day of our announced inspection.
- The nursing staff organised their breaks to ensure an evenly distributed skills mix and numbers.

Medical staffing

- The consultant to patient ratio across ICU was 1:8, if all the beds in the unit were occupied. This was in line with the Intensive Care Society core standards for intensive care units guidelines that state the ratios should not exceed 1:8 to 1:15.
- The consultants who participated in intensive care working rotated for a week at a time.
- A junior and senior trainee specialist/doctor was on site each day. One senior trainee doctor was on duty overnight. There was overnight consultant on-call cover provided by a first and second responder.
- Medical handover meetings took place each morning for an hour from 8am. The doctors on duty overnight updated the day-shift team on any new patients admitted overnight, changes or concerns in current patients and any patients who could be stepped down to a ward. We observed a morning handover meeting and noted individuals were given specific tasks, teaching/learning opportunities were discussed and any other business issues were identified.
- The day shift handed over to the senior trainee doctor covering overnight at 6pm each day.

Allied Healthcare Professionals

- The Intensive Care Society core standards for intensive care units states there must be a dietician as part of the critical care multidisciplinary team. The British Dietetic Association recommends that there should be 0.05-0.1 whole time equivalent (WTE) dietician per one bed and that the lead dietician for ICU should be at least a band 7. There was minimal input from the dietetic department and it was reported they were only referred to when patients required complex feeding regimes. Consultants reported “little need of dietetics”.
- The physiotherapy team worked across the Trust at both Queen’s Hospital and King George Hospital. At Queen’s it consisted of one band 8, one band 7, two band 6 and one band 5 member of staff. The physiotherapy team at King George hospital consisted of one and a half band 7, one band 6 and one band 5 member of staff. They supported critical care and surgical patients and staff across King George Hospital
- The surgery and critical care teams had access to two dedicated occupational therapists from the overall team of occupational therapists who worked at the hospital. Staff reported that there was limited input from the team as they were unable to manage the workload, due to the small size of the team.
- There were no tracheostomy trained speech and language therapy staff, therefore, the physiotherapy team supported patients with some swallowing difficulty techniques.

Major incident awareness and training

- All staff attended fire safety training as part of their mandatory training. Staff were able to explain what they were expected to do should they be required to evacuate the critical care areas. None of the staff we spoke with had rehearsed a fire evacuation, however, a film on how to evacuate critical care units had recently been made for Queen’s Hospital. It had not been released for viewing at the time of our inspection.
- Senior nursing staff were able to verbalise all aspects of preparing for an external major incident. Junior nursing staff told us it was their responsibility to continue to care for their patients and wait to be told what to do by senior staff.
- Staff told us in the event of a power outage there would be failure of lighting, monitoring equipment and probably IT. They told us they would expect the generator to provide them with power quickly. There was access to torches should there be total power failure resulting in complete darkness.

Are critical care services effective?

Good

Care delivered was measured routinely to ensure quality and improve patient outcomes. The unit’s mortality rate was slightly under 1%, which was comparative to units of a similar size. We found the care delivered in the department was evidenced-based and adhered to national and best practice guidance.

Staff were competent to deliver safe and effective care. Over half of the nursing staff on duty had completed an intensive care course, in line with current guidance. All staff received an induction into the unit and agency staff competencies were checked by senior staff prior to working independently.

Records showed discussions were held with patients and families around consent and formal documentation was completed. Mental capacity assessments were completed

and best interest conversations were held with family or an independent advocate, where appropriate. Deprivation of Liberty Safeguards assessments were completed, where appropriate.

There was little evidence of a multidisciplinary team approach. Physiotherapists spoke with the consultants, but did not attend the medical or nursing handover. Occupational therapists, speech and language therapists and dieticians did not routinely attend multidisciplinary team meetings, however, they were accessible on a referral basis.

Evidence-based care and treatment

- Policies were based on NICE and the Royal College of Surgeons' (RCS) guidelines, where appropriate, and care was provided in line with National Confidential Enquiry into Patient Outcome and Death and RCS guidelines.
- We saw protocols and guidelines used for medical and nursing management were referenced to national and international guidelines.
- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit & Research Centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit had a physiotherapy-led ventilator weaning programme in place. This approach meant that the care delivered was more effective and may have an impact on length of stay.

Pain relief

- The critical care units used a standardised pain scoring tool.
- Patients reported being regularly asked about their pain levels and offered appropriate medication if required. A relative described how the staff observed their family members movements while they were unconscious. They had been concerned the movements indicated the patient was experiencing some pain. The consultant prescribed medication to help reduce it.
- If treatment was no longer benefiting a patient a decision was made in conjunction with family members/advocates to withhold life-sustaining therapies, care and medication. A move was then made towards providing comfort and palliation to reduce any distressing symptoms in the last stages of the patient's life.
- Staff could refer patients of concern to the pain nurses. The nurses also offered advice on the occasions they visited the unit.

Nutrition and hydration

- Critical care patients' nutrition and hydration requirements were assessed and reviewed daily by the medical teams. Staff could refer patients of concern to the dietetics service.
- A set protocol was used for nasogastric tube feeding.

Patient outcomes

- The unit participated in a national database for adult critical care as recommended by the Intensive Care Society core standards for intensive care units. They contributed data to the Intensive Care National Audit & Research Centre (ICNARC) database for England, Wales and Northern Ireland.
- Results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with other similar services.
- ICNARC 2015 data showed the number of unplanned readmissions to GICU/HDU within 48 hours was within acceptable limits and, on average, with comparative hospitals, however, it was slightly worse than the Clinical Reference Group's (CRG) threshold. The CRG threshold is based on the median across all critical care units in the ICNARC Case Mix Programme (an audit of patient outcomes from adult, general critical care units) during 2012/13.
- The hospital mortality rates for the unit were comparative to other units of a similar size at 1%.
- Senior staff reported difficulties in discharging patients back to the referring consultant if the consultant was based at Queen's Hospital and did not ordinarily work at King George Hospital. This could delay discharges if not pre-empted by nursing staff.
- The unit performed other local audits such as using the National Early Warning Score (NEWS) accurately and escalating appropriately. It was a positive audit and escalation had been appropriate. Local feedback was given to the team.

Competent staff

- All temporary nursing staff, such as agency nurses, were required to complete a local induction on their first shift. The induction checklist included policies relating to medicines handling and administration, child

protection, health and safety and incident reporting. Agency staff were shown how to use equipment and their competencies were checked by a senior member of staff.
- Newly qualified registered nurses were supernumerary on the units until they achieved the required competencies in critical care to work with patients independently.
- Nursing staff were required to achieve specific competencies, such as tracheostomy care, nasogastric tube, suctioning, citrate and sepsis before working alone with patients. Once staff acquired the relevant competencies they were allocated to patients who required the staff member to embed their learning prior to moving on to a higher acuity patient. Once they were deemed proficient in the areas identified they could progress and, with support from an experienced colleague, care for a patient with different critical needs.
- Records showed that 97% of staff had received an annual appraisal. Staff we spoke with were positive about the experience and described the value of an annual review to discuss their achievements and goals.
- An intensive care course for nurses was available. Staff reported that it was difficult to get a place on the course due to lack of funding. The trust provided ten places per year, two of which were allocated to staff on the unit at King George Hospital.
- Nurses were encouraged to be a 'champion' on particular clinical areas, such as: falls, pressure ulcers, infection prevention and controls, safeguarding and nutrition.
- Medical staff discussed time and the ways they taught trainees in times of low workload. Trainee doctors told us that it was "well known in the trust that it's the hardest rota but the best teaching".
- Nurses were supported on the unit by a nurse educator.

Multidisciplinary team working

- All care and treatment for patients admitted to the ITU was the responsibility of the anaesthetists or intensivists on the unit. Responsibility for care transferred to the medical or surgical consultant who initially referred the patient to critical care once they were discharged to the ward.
- We observed the urology and cardiology team attending the ward round on the day of our inspection which showed some multidisciplinary team working.
- The physiotherapy team and specialist nurses for organ donation supported staff and patients in the ITU on a daily basis.
- Dieticians were not routinely involved. Patients were referred to the dietetics department if they had a complex eating regime. Consultants felt confident to prescribe appropriate nutrition for patients.
- Speech and language therapists were available on request. However, we were told there were no tracheostomy-trained staff at the time of our inspection.
- Occupational therapists were involved in discharge planning for patients returning home. This was supported by the physiotherapy team through joint home visits to assess a patient's home for any equipment or access needs.
- Pastoral support was available 24 hours a day from the chaplain. This included providing support to staff.
- Patients from critical care were followed up on the ward by the CCOT within 24 hours of discharge from the unit.

Seven-day services

- The CCOT was available seven days per week from 7.45am to 8.15pm.
- Critical care patients were prioritised for scans and imaging. Staff reported no problems with access services quickly at any time of the day.
- The physiotherapy team worked Monday to Friday during the day and started at the medical handover meeting at 8am. An out-of-hours, on-call service was provided. Physiotherapists attend on Saturdays and Sundays to treat patients and an out-of-hours on call service was also provided.

Access to information

- All staff we spoke with found the IT systems frustrating to navigate and difficult to access due to a lack of computer terminals. For example, we searched for blood products guidelines and found the page was not available and identified as an error. However, we were told by a number of staff that there was a plan to have a new IT system and software interface installed.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Consultants described how they obtained consent from the patient and/or relative whenever possible. Records showed details of discussions and formal consent was documented, where appropriate.

Critical care

- Mental capacity assessments were completed for people who were suspected as not having capacity to consent. Best interest conversations were held with the family or independent advocate, where appropriate. Assessments were also completed for people who chose to discharge themselves.
- Staff had access to the trust's consent policy on the hospital's intranet.
- Deprivation of Liberty Safeguards assessments were completed, where appropriate, such as in the use of mittens to prevent patients from pulling at tubes and hurting themselves. However, under Havering local authorities procedures there was no requirement for the hospital to inform the council of depriving a patient of their liberty unless they were known to have a mental health diagnosis. Families were informed of Deprivation of Liberty Safeguards as soon as practicable.

Are critical care services caring?

Good

We observed that patients were treated with dignity and respect at all times. The staff were described as "amazing" and we were told, "The doctors were clear [in their explanations]."

Patients and relatives told us they were involved in the care planning process and felt well informed. We saw that family members were encouraged to support their relative by performing some personal care tasks or reading to them.

Patients' families told us difficult conversations were held in private, handled well and in a sensitive manner. Discussions were held in a way the patient and their family could understand. One family member told us, "The doctor has had a meeting with the whole family, it's quite a task as there are a lot of us, but everything was explained in a way that we all understood."

One family told us they had spoken to other families in the waiting room. They said, "Everyone remarked how good it was."

Compassionate care

- We observed staff displaying concern for their patients and heard them speak with respect. Consultants greeted patients and their relatives and friends and enquired how they were. All interactions were caring, professional and appropriate.
- All staff worked quietly and did not hold any unnecessary conversations amongst themselves. They showed respect to the patient and explained what they were doing throughout any treatment or care, even when the patient was in an unconscious state. A family member told us, "The nurses talk to my relative about everything they are doing even though they are not awake."
- Inscriptions in 'thank you' cards displayed at the entrance to the units indicated how much patients and their families had appreciated the friendly and supportive staff during the difficult time they had been through.
- Relatives and friends were encouraged to help support the patient with some aspects of care, such as washing their hair or applying cream to their feet if they felt comfortable to do it. Other ways visitors could support their relative was through reading to them and helping to feed them. We observed a family member combing their relative's hair.
- A relative told us staff had given compassionate care even though they were unconscious and not going to be regaining consciousness. They said, "My relative's hair was brushed and neatly plaited every day. The staff regularly changes their bed and clothing and made them comfortable."
- We observed curtains were fully closed when staff were treating or performing personal care tasks.
- Patients were discussed by name and their social situation was included in the nursing staff handover.

Understanding and involvement of patients and those close to them

- Relatives of patients spoke positively about the staff involving them in their family member's care and treatment. One person said, "The doctor has been very clear. They have been very good at explaining everything in a way we understand and without giving false hope."
- Patient records reflected conversations held with families and the notes included any responses from the family.

Critical care

- We were told the specialist nurse for organ donation (SNOD) explained the whole process for organ donation in a clear, supportive and impartial way. The family we spoke with told us they appreciated having time to make the decision and felt there was no pressure to comply.
- The CCOT had devised a tracheostomy discharge checklist for patient's leaving the hospital with a tracheostomy. The checklist supported teaching patients, family and carers in how to support a person with a permanent tracheostomy. Key competencies, such as (amongst others): suctioning, care of stoma site, equipment, action to take in the event of an emergency were checked and signed off. This meant patients and their carers had a clear understanding of the equipment, the care required and support they needed.
- We observed consultants welcoming relatives and involving them in their ward round with their family member.

Emotional support

- Consultants reported that they broke bad news to patient's relatives in private with the support of a nurse and pastoral support if the family requested it.
- Patients' families told us that staff had told them to call the unit at any time, even overnight, if they were at all worried.
- Chaplaincy was available for patients, families and staff. We were given examples of chaplaincy support for families and staff. The chaplain could offer Christian and spiritual support, as well as access local spiritual leaders from other religions.
- If a patient had mental health concerns, psychiatric support could be accessed through the hospital.
- The outreach team described how they supported patients coming to terms with life-long changes such as a permanent tracheotomy.
- The SNOD explained the support they gave families in considering donating their relative's organs once they had been identified as dying and suitable for donation. The SNOD nurse's support was unconditional and they remained with the family throughout the dying stages, even if the family had decided not to donate their relative's organs. The family we spoke with told us the SNOD and nursing staff had provided emotional support for all the family and had reassured them they would be there when life support was withdrawn.
- The CCOT told us patients who had left hospital and were finding it emotionally difficult to live with a tracheostomy often called them. A member of staff said, "We can spend quite a time on the phone offering friendly support and advice. We also suggest they attend the monthly outpatient clinic."

Are critical care services responsive?

Requires improvement

There were insufficient critical care beds available for the population served by the Barking, Havering and Redbridge University Hospitals NHS Trust in comparison with other London hospitals.

Some attempt to mitigate bed shortages was made by using the recovery area to support patients until a bed became available, but capacity has remained high at an average of 95%. This meant that accessing critical care beds has been difficult for some patients, such as those who have planned procedures which required a high level of support postoperatively.

There was a small waiting area with chairs, a sofa and refreshments for relatives, however, there was no dedicated overnight accommodation or bathroom facilities for those who wished to stay. We observed how the staff tried to accommodate a large family who were visiting so that they could all spend time with their relative during the last hours of their life. This was done with minimal disruption to other patients and families.

The outreach team assisted ward-based staff in the early identification of patients at risk of deteriorating and who may require an High Dependency Unit (HDU) or Intensive Care Unit (ICU) bed. The Critical Care Outreach Team (CCOT) also provided an outpatient clinic to support previous critical care patients in the months after their admission to ensure they continued to progress.

Staff were aware of supporting patient's individual needs. They used a variety of communication tools, such as the Hospital Passport for patients with learning difficulties, pictures and translators when needed.

Service planning and delivery to meet the needs of local people

- Based on the London average of seven acute critical care beds per 100,000 population (Intensive Care Society/Faculty of Intensive Care Medicine data, January, 2014) the trust should have 50-70 critical care beds to support its local population.
- The trust is the seventh busiest for general critical care in the country by the number of admissions, but only 30th by the number of general critical care beds. King George Hospital has eight critical care beds. It was usual for five level 3 patients and three level 2 patients to be admitted, however, the unit was able to be flexible to the acuity of the patients with appropriate nursing support.
- The clinical lead for intensive care medicine had produced a paper on 'Planning General Critical Care Capacity' at the Barking, Havering and Redbridge University Hospitals NHS Trust. The plan estimated an expansion of the service would realistically take three to five years to relocate the critical units, possibly in a new building.
- The unit at King George Hospital had been under threat of closure as the A&E had been planned to close, however, this had not happened and the decision had been made that, while the A&E was still open, critical care would remain available at the hospital.
- The CCOT provided a 'critical care follow-up outpatients clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their admission.

Meeting people's individual needs

- Families were encouraged to bring in electronic equipment such as tablets and DVD players for patients who were conscious. We saw one long-term patient had a DVD player to use.
- The waiting room for patient's families was small and not large enough for the number of visitors waiting to see their relative or friend. On one occasion, we observed that there were not enough seats for everyone, which left people standing in the corridor outside the unit.
- The waiting room doubled up as an area for relatives to stay overnight if they wished to. There were no bathroom facilities available to anyone who stayed overnight.
- Patients with learning difficulties used the Hospital Passport, which was a communication book. It provided a picture of the whole person, by including information that was not only about illness and health. For example, it included lists of what the patient liked or disliked, from physical contact to their favourite type of drink, as well as their interests. This helped the hospital staff by giving them insight into how to make patients feel comfortable. We observed the passport in use for one patient admitted to the unit.
- Communication books with pictures were available to use with patients who could not understand English or who had learning difficulties.
- Translation services were available through a telephone translation service or with a face-to-face interpreter with prior booking. Staff reported the translation services were rarely used as the over the phone system was difficult to use and interpreters were hard to organise at a time when all parties were available. Staff told us they did not face the issue often as there was usually someone in the family who understood English, although they would not ask a child to translate. There were also some staff that spoke other languages and could, occasionally, be used to translate.
- Mixed sex breaches happened occasionally, due to the limited number of intensive care beds. Therefore, patients were placed in the unit based on a clinical decision as opposed to their gender – although staff were mindful to keep breaches to a minimum and made arrangements where possible to position patients of the same gender together. Privacy was also provided by use of curtains, or one of the two side rooms.
- Parking permits were available for visitors while their relative was admitted to ITU.

Access and flow

- Patients were admitted to ITU through A&E and the acute medical unit after surgical procedures, or from wards where the patient was identified as deteriorating and requiring high dependence or critical care. Occasionally, patients were transferred from Queen's Hospital.
- In the five years up to 2013, the number of admissions within the trust had more than doubled to nearly 400 per year. Bed capacity was an average of 95% over the year prior to the inspection, reaching 100% on some occasions.
- ICNARC data for 2015 showed that for the ITU there were no concerns regarding non-clinical transfers (out), or

delayed discharges (12 and 24 hour), out of hours and daytime discharges to the ward, which all came within an acceptable range and were better than the comparator for 12 and 24-hour delayed discharges.

- However, the ICNARC data for 2015 indicated that out-of-hours discharges (not delayed) were worse than the comparator, but still within the accepted range.
- Staff reported considerable pressure for beds within all areas of critical care. A recent report by the hospital on 'Planning General Critical Care Capacity' identified that the lack of capacity directly affected 100 to 200 patients every month. This resulted in cancelled major operations, including cancer work, delayed initiation of emergency treatments, patients not receiving optimum or timely interventions and evidence of worse outcomes for some patient groups.
- Staff told us the demand for beds at King George Hospital could be variable, "Some days the ward can be full and then we can have empty beds the next day." On the day of our inspection, there were two patients whose planned procedures required a higher support of care after their operation. Staff were assessing whether they could support the two patients in the recovery area over night. However, there was an issue in finding suitably qualified staff to support them, which meant their procedure would be cancelled.

Learning from complaints and concerns

- We reviewed the complaints data provided by the trust. Between April and December 2014, there were no complaints relating to ITU. We saw that complaint records for other departments had been investigated and any issues were identified. However we noted the records did not indicate the outcome of the complaint or what learning was shared with staff.
- Staff we spoke with could not readily identify any changes or learning from comments or concerns patients or their relatives made while admitted to the unit.

Are critical care services well-led?

Requires improvement

We found the leadership team had a strong vision for the expansion of the critical care services, however, staff at King George Hospital were not aware of how it would affect the unit's future and their jobs. We found there was some cynicism towards the trust's vision and strategy.

The consultants, doctors, nursing staff and other Allied Health Professionals tended to work in silos, providing little opportunity for multidisciplinary learning or innovation. Senior medical staff were not readily able to describe morbidity and mortality, risks or incidents in relation to the unit.

All the staff we spoke with were focused on delivering high quality, safe and effective care to patients. We found that, at a local level, there was strong support within the team and there were some mechanisms to share information across all the staff working in King George Hospital's critical care unit. However, we found there was little shared learning across the critical care units within the trust and staff at King George Hospital felt their opinions were not listened to.

Vision and strategy for this service

- The senior management, senior nurses and consultants were all committed to their patients, staff and the unit. The vision of the unit was to provide the best quality care and outcome for seriously-ill patients by highly qualified, trained professionals. One member of staff said, "We are a small unit, so like a family, we care for our patients and support one another."
- The senior management team had a strong vision for critical care services provided by the Barking, Havering and Redbridge University Hospitals NHS Trust. They spoke passionately about proposals to expand the service once an appropriate location and funding was secured. These plans had not been openly shared with all staff as the senior team were aware there had been many discussions in the past, which had lead to feelings of instability amongst staff.

- Staff told us they were told that, while there was an A&E department at the hospital, there would be a critical care unit to support it. The senior sister told us this had caused some difficulties with morale. However, they felt they were managing the concerns.

Governance, risk management and quality measurement

- Staff were encouraged to report any incidents, including staffing issues. The team met together on a monthly basis to discuss any issues, concerns, policy and procedural updates and general business. The minutes were available the following day via email and a hard copy was made available. Staff reported positively about the meetings and felt able to voice their opinion.
- Consultants from King George Hospital attended governance meetings which were held at Queen's Hospital. We had some concern that they may not always be able to attend. We found that a lead consultant was less familiar with the risks, incidents and morbidity and mortality within the critical care unit than would be expected.
- The consultants held a monthly clinical governance meeting. The division's risk register was emailed monthly to the consultants and discussed at their Monday morning meeting.
- The senior sisters met regularly with their counterparts at Queen's Hospital. Staff at King George Hospital reported there was little shared learning and thought that the unit at King George Hospital was seen as the "poor relation".
- Any issues, concerns, policy or procedure updates were placed in the unit's communications folder. It was the responsibility of the team members to update themselves and in the case of new procedures to sign to say they had read it. We were told that any changes would be identified at handover and staff would be reminded to read the information during their shift.

Leadership of service

- The day-to-day running of the unit was overseen by a senior sister. They reported to the matron responsible for ITU/HDU, who was based at Queen's Hospital. The matron reported directly to the divisional director, divisional manager and divisional nurse, which was currently vacant.
- We were told the chief executive had relocated some of the senior team at King George Hospital to make the senior team more accessible to staff across the whole trust. They had previously all been located at Queen's Hospital. The senior sister told us the senior lead at the hospital was accessible and approachable. They said, "If I had any concerns I could go to them."
- Staff reported a mixed opinion of the support they received from the senior critical care leaders based at Queen's Hospital. One person said, "It's [the support] up and down. We have ideas and opinions, but it feels like we have to do everything their [Queen's Hospital's] way, but it doesn't always suit this unit."

Culture within the service

- We found a cohesive team managing the ward at a local level. Staff worked hard and had a flexible approach to ensure as many patients as possible could be safely cared for in what was already a busy unit, that was running at full capacity most of the time.
- Staff were proud of their unit and all the staff we spoke with were focused on delivering high quality, safe and effective care to patients.
- The unit had trialled working in fixed teams to work in line with the teams at Queen's Hospital. However, the system did not suit the unit at King George Hospital. Staff enjoyed working with different members of the whole team and it was easier to ensure experienced staff were present on each shift.
- We observed senior staff were supportive of the junior staff and very much part of the team. They regularly covered breaks periods so that nursing staff could take their rest period at an appropriate time.
- The team were supportive of one another. We were told of instances when they supported each other through particularly emotional situations, such as when a long-term patient died. Staff were supported to attend a patient funeral if they wished to.
- We found some cynical attitudes towards the trust vision and strategy. Some staff were not engaged with the trust's core values, PRIDE (Passion, Responsibility, Innovation, Drive and Empowerment). There was an incident where staff felt someone's actions could have "sabotaged" the reputation of the unit. A blow-up mattress was found in the men's staff toilet. A photo of the mattress was sent to the matron. The staff on the unit felt the photo implied they were sleeping during

their shifts. The senior sister told us they had no idea that the mattress was there until the matron spoke with them. She said, "That action doesn't seem like teamwork to me."

Public and staff engagement

- Staff had mixed opinions on how visible the board and executive team were. The clinical director and chief executive were well regarded and a number of staff told us they had seen them on the ward talking with staff and enquiring about their role. Staff knew of the monthly meetings held by the chief executive, but most of them were unable to attend due to the time of day it was held.
- We were told some senior staff had been located at King George Hospital to make the senior team more accessible to staff across the whole trust. They had previously all been located at Queen's Hospital. The senior staff told us they were approachable and would speak to them if the need arose.
- A patient survey was given to patients and relatives in ITU. However, patients rarely completed the survey until they were discharged from the hospital via the general wards, and, therefore, the information did not necessarily relate to care given in critical care. Staff told us they relied on the 'thank you' cards and immediate feedback from patient and families to know how well they were doing. They did not know how well they were performing from surveys. This also gave little opportunity to improve the patient experience as a result of patients' comments or suggestions.

Innovation, improvement and sustainability

- The nursing staff were encouraged to suggest and trial new ideas. For example, they had designed a system to ensure the three citrate bags prescribed for dialysis were checked. There was a column for the doctor's signature, as well as for the nurse who was putting up the bag and the nurse witnessing it. This record was printed on a sticker, which was attached to the nursing notes.

Services for children and young people

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

Information about the service

King George Hospital serves a population of 270,000 children and young people, mainly across the London boroughs of Barking and Dagenham, Havering and Redbridge and parts of Essex. Less than 1% of cases were elective, 3% were day case, 92% were emergency. In outpatients for children under the age of 16, there were 1,430 new attendances and 1,742 follow-up attendances in 2014.

During our inspection, we visited Clover Ward, which provided inpatient services for children and young people. The ward has 14 inpatient beds and an additional four day case beds available if necessary.

We spoke with three patients and seven parents. We also spoke with 17 members of staff, including paediatric doctors, theatre staff, nurses (bands 5 to 8b), healthcare assistants, domestic staff, phlebotomists, radiographers and sonographers. We observed care and treatment and looked at care records. Prior to, and following, our inspection, we reviewed performance information about the service, and information provided by the service.

Summary of findings

Although staff were aware of the incident reporting system, incidents were not always reported. Paediatric resuscitation equipment was not always checked in some areas of the hospital. We found there was a lack of paediatric life support training for theatre staff who may be involved in treating a child or young person whose condition suddenly deteriorated.

Not all records were stored securely and confidentially. There were issues around obtaining records and tracking temporary notes, which meant a full set of notes was not always available.

The service children experienced during visits to the hospital for phlebotomy did not meet their needs. There were limited resources available for children with mental health needs and no paediatric physiotherapist.

Paediatric services had a lack of developed governance systems which meant that risks were not always identified and escalated appropriately within the division to the patient safety team for appropriate management.

Staffing on Clover Ward was not always sufficient. However, specialist nurses were brought in as necessary to provide cover. Although an acuity and dependency tool was available to calculate ward staffing levels, the data was not always updated on the system.

Services for children and young people

Observation of interaction between staff and patients was very positive. Parents told us they were involved in discharge planning and told us they were very happy with the attention their children received while staying on Clover Ward.

Are services for children and young people safe?

Requires improvement

Although staff were aware of the incident reporting system, incidents were not always reported.

Medicines were appropriately stored and controlled and we observed safe practice during administration.

Not all records were stored securely and confidentially. There were issues around obtaining records and tracking temporary notes which meant a full set of notes was not always available.

Although most mandatory training was up to date, there was a lack of Advanced Paediatric Life Support (APLS) training, though plans were in place to address this.

We observed the ward to be clean during our inspection, however, there were no records to evidence that ward cleaning was carried-out routinely.

The resuscitation equipment on Clover Ward was appropriately maintained and regularly checked. However, resuscitation equipment in the computerised tomography (CT) scanning area was not routinely checked, and the resuscitation trolley near theatre had an out of date list of equipment.

The hospital used a Paediatric Early Warning Score (PEWS) to monitor the deterioration of a child, and every child was seen by a consultant paediatrician within 24 hours of admittance. However, the hospital was unable to guarantee that staff involved in managing a deteriorating child would be paediatric trained. We found there was a lack of Paediatric Intermediate Life Support/Advanced Paediatric Life Support and European Paediatric Life Support training for theatre staff who may be treating a child or young person whose condition suddenly deteriorated.

Staffing on Clover Ward was not always sufficient, however, specialist nurses were brought in as necessary to provide cover. The trust had a lower proportion of consultant grades and a considerably higher proportion of junior grade doctors compared to England averages.

Incidents

- There was one serious incident reported in 2014.
- Staff were able to explain the incident reporting procedure and gave us examples of when they had used the process. The Ulysses incident reporting system required staff to log in with an ID and staff told us that some staff had been worried about reporting incidents in case they were blamed for the incident. However, staff also told us that they felt things had improved and staff were less worried than they had been in the past.
- A member of staff we spoke with was able to describe the changes that had occurred as a result of reporting an incident.
- Staff were not always logging staff shortages as incidents. The trusts overall statistics for reporting incidents were lower than the England average, at 7% against 9%.
- One incident that occurred during our inspection was appropriately escalated and responded to quickly.
- Staff were aware of monthly incident reports but told us they had not seen any.
- When talking about incident reporting, a senior member of staff told us, "Our band 5, 6 and even 7 nurses need some help and coaching with this."

Cleanliness, infection control and hygiene

- The Infection control link nurse for Clover Ward had recently joined the central infection control team and so there was no link nurse for the ward at the time of our inspection.
- We saw several audits for monitoring infection control, such as an environmental audit which scored 100%. Hand hygiene audits were normally carried out weekly, however, we saw there was a gap in January when the audit had not been carried out.
- The 'bare below the elbow policy' was adhered to by staff.
- We did not see any records or checklists to show that cleaning had been completed as appropriate and staff confirmed they did not use a checklist. However, cleaning guidelines were available in the Control of Substances Hazardous to Health (COSHH) cupboard and we observed all areas of the ward were clean.
- Staff told us, "We know what we have to do and start at the front of the ward," and, "I know the cleaning will get done."
- Staff explained the colour-coded system in use for different areas of the ward. This meant the risks of cross contamination were reduced. All cleaning solutions were locked away on a cleaning trolley to keep them out of the reach of children. Information was available for safe systems of working and avoiding injury. Information was also available for the cleaning solutions in use.
- Information and guidance about the cleaning materials to be used on Clover Ward was available. However, some of the guidance was out of date and other guidance did not have a date.
- Results from the patient-led assessment of the care environment (PLACE) showed the trust, as a whole, scored below the England average for cleanliness. However, the PLACE scores for Clover Ward collated in August 2014 demonstrated a high compliance against standards.
- We saw appropriate use of waste disposal such as coloured bags for clinical waste. Bins had labels and pictures on them to explain what type of waste they were to be used for.
- It was possible for one bay on Clover Ward to be isolated so that if necessary, it could be used for barrier nursing.

Environment and equipment

- The resuscitation trolley on Clover Ward was appropriately maintained and checked regularly. Staff initialled records to show that they had checked the trolley. However, we saw resuscitation equipment in the CT scanning area that was past its use by date. We highlighted this to staff and when we checked the following day, the out of date equipment had been replaced.
- The resuscitation trolley near the theatre did not have an up-to-date list of equipment. We found the list of equipment document was dated 2010 and was not compliant with the 2012 Resuscitation Council (UK) guidelines. Additional items had been listed in pen.
- Portable appliance testing was up to date on electrical equipment. Staff told us that fire alarms and the emergency generators were tested regularly.
- Clover Ward was appropriately decorated with child-appropriate wall art, and cartoon characters.

Medicines

- An on-call pharmacist was available although the pharmacy stock was maintained at Queen's Hospital. Clover Ward kept a supply of basic medicines for children to take away when they were discharged, however, any specialist medicines needed to be arranged specially.

- As an additional safety measure, patients with allergies wore red wristbands with their allergies identified.
- Nurses used to complete a medicines management pack if they were responsible for a medicines error. However, at the time of our inspection, everyone completed a pack within a few months of starting work on the wards. Nurses were observed administering medicines and 100% of nurses had completed the necessary competency assessments.
- The process for giving medicines to patients when they were discharged was safe because the medicines policy was followed and there was a suitable stock control processes in place. We saw two nurses signing when medicines were given to patients to take away with them when they were discharged.
- Medicines were appropriately stored and controlled.

Records

- Staff told us notes were obtained from the medical records department and said, "We regularly don't get a full set of notes," and, "There are some issues with notes going missing."
- They said that most notes were available the same day. However, there was a new folder system for temporary notes and staff said that, as they could not create a log on the system, no-one was aware of the existence of the temporary notes. This also meant they could not be tracked.
- There was no cover for the clerk on Clover Ward when they were absent. Nurses sometimes updated systems but not always. However, only the ward clerk tracked notes.
- Ward records were kept in a notes trolley at the nurses' station; this meant they were secure and kept confidentially. We saw confidential information with patient identifiable information left unsecured on the desk in the outpatient clinic, which adjoined Clover Ward. This was pointed out to a member of staff, who secured it.
- We saw the admittance records for one patient to Clover Ward. An appropriate plan of care was in place and the date, time and name was printed and signed. Also, the person's designation had been recorded.
- Other records we saw were maintained to a good standard, overall.

Safeguarding

- Nursing staff working on Clover Ward had completed level 1, level 2 and level 3 safeguarding children training. Staff were able to give examples of safeguarding issues and processes, and were able to describe what would make them concerned about a child. Staff told us key learning points from their training, which included the importance of communicating with multi-disciplinary teams and the importance of completing documentation.
- Child protection plans were discussed in weekly psychosocial safeguarding meetings. Ward staff were made aware of alerts concerning the welfare of children from A&E. Round table meetings had been held on the ward, when social workers and others involved with the child such as school, safeguarding, parents and ward staff had all been involved. As a result of these meetings, safeguarding alerts had been made.
- We asked staff if they knew what to do should a child be at risk of being abducted. Staff said they had an abduction policy but were not clear about this and thought this applied to maternity only. Staff told us they were clear on admission of a child whether there were any issues with parental contact.

Mandatory training

- Staff completed mandatory training which included safeguarding, resuscitation, basic life support, manual handling and infection control training. We saw the training matrix which showed staff training was mostly up to date; staff had been provided with training dates for courses they were due to attend where necessary.
- Although the Paediatric Basic Life Support training for the majority of theatre staff was in date, one nurse had not received further updates for four years. Other staff training was out of date by a couple of months and there was a group of new staff who were waiting for a date for their training.
- Staff were reminded and supported to update mandatory training when due. More training was completed in the summer months which meant there were fewer pressures with staffing during winter pressure months.

Assessing and responding to patient risk

- The hospital was unable to guarantee that staff involved in managing a deteriorating child would be paediatric trained. We found there was a lack of Paediatric

Intermediate Life Support, Advanced Paediatric Life Support and European Paediatric Life Support training for theatre staff who may be involved in paediatric deterioration.

- The hospital used a Paediatric Early Warning Score (PEWS) to monitor the deterioration of a child and children were moved to a recovery bay if necessary.
- Every child was seen by a consultant paediatrician within 24 hours of admittance. There were at least two ward rounds each day, sometimes three.
- There was access to a senior children's nurse for advice at all times throughout a 24 hour period.
- Link nurses for health and safety and the senior sister did risk assessments where necessary to support the delivery of safe care.
- When a child required resuscitation, the paediatric registrar, paediatric senior house officer, an anaesthetist registrar and the site manager all responded. If necessary, a consultant paediatrician and anaesthetist would be called.
- When older children were admitted to the Intensive Therapy Unit, paediatric support was provided to ensure the child's needs were considered.

Nursing staffing

- One parent told us, "They've had a handover and staff know my child's needs."
- Staffing on the ward was generally one to five, except for the nurse in charge who had four patients. We were told, "We look at the number of staff we have and the number of children we have and say how many children we can safely look after. Bed pressures sometimes mean we have to take children, though we complete incident forms when this happens." Staffing levels were not increased if children under the age of two were on the ward.
- Clover Ward was 1.76 band 5 nurses short of the amount budgeted for.
- There was usually one band 7 nurse on duty Monday to Friday and available on the phone during nights and weekends. There was at least one band 6 nurse on duty per shift. On the day of our inspection, the ward was short staffed. An agency had been contacted to supply staff, but it had not been possible to fill the vacancy. Staff told us they were normally able to cover absences, but we were told, "Lately, we seem to be struggling."
- The use of bank and agency staff, overall, for the trust was higher than the England average, at 10% against 6%.
- To be able to respond to winter pressures, additional staff were obtained either by employing agency staff or moving staff from other areas. If necessary, the number of beds available was reduced. Also, if necessary, a neonatal nurse would be brought in to provide specialist services on the ward.
- There was one registered mental health nurse on duty to provide a one-to-one service.

Medical staffing

- There were 17.9 paediatric consultants that worked across both sites.
- Senior house officers and registrars were available. Consultants were available during the day and were on call at night".

Are services for children and young people effective?

Requires improvement

National audit figures showed that the multiple admission rates for children with asthma and the number of emergency readmissions within two days of discharge for non-elective patients compared favourably with the England average. However, the trust scored lower than the England average for multiple admission rates for children with diabetes and medical oncology.

Evidence-based paediatric assessment tools for assessing nutrition and hydration needed embedding. While a varied selection of food was available, Friends and Family Test results showed respondents felt that food quality needed to be improved.

Staff were supported with regular reviews. New nursing staff were provided with a preceptorship for the first year in post.

Evidence-based care and treatment

- The policies in use were based on National Institute for Health and Care Excellence (NICE) and Royal College [ST1] guidelines. Staff told us NICE guidelines were sent to the ward and were available for staff. Information

given to us by the trust showed the compliance rate with NICE guidelines for the year 2013 to 2014 was between 51% and 59%. The trust's target for compliance was 90%.

- Senior clinicians and managers told us they used a range of guidelines that had been produced by NICE and the Royal College of Paediatrics and Child Health (RCPCH) to define the treatment provided. For instance, we saw that in line with NICE guideline (Neonatal Jaundice, CG 98) a weekly jaundice clinic was in operation.
- We found local nursing audits included safeguarding (the results of which fed into the safeguarding operational board), hand hygiene, 'Fit to fly' (this is where resuscitation trolleys were checked etc.) and a quality of care audit. Paediatric Early Warning Score (PEWS) audits were conducted monthly as was admittance documentation. Other audits included name bands, falls, catheters and patient transfers. The results of the various audits were fed back to the staff monthly via the results board.
- Every patient bed area was checked twice per shift.

Pain relief

- A nationally recognised system was in use for younger children, and staff asked older children to describe their pain on a 0 to 10 scale. Staff we spoke with described how they used the pain assessment tool.
- Staff of various grades gave many examples of hospital play specialists providing distraction therapy as part of pain management.
- Parents and patients we spoke with told us analgesia was given to prevent pain/discomfort. One parent confirmed their child has been asked to describe the pain they were experiencing on a 1 to 10 scale and had been given pain relief. We saw the results of the NHS Friends and Family Test where 100% of people asked rated the ward good at managing pain.
- Staff told us they were always able to get someone, such as an anaesthetist or a member of the 'pain team' to be able to manage pain if necessary. Senior staff told us that they had access to the adult pain relief team for support, but said that the provision for children was something they could improve on.

Nutrition and hydration

- We saw comments in the NHS Friends and Family Test that food was poor and portions were small. However, there was a newly appointed nutrition nurse in post and senior staff told us they intended to discuss this feedback with them. Ward staff told us, "The food is not horrendous, but it's not brilliant either," and, "Children can choose from a trolley on the ward. There's a good selection of vegetarian, halal and kosher food."
- Staff said a nutrition link nurse was available for guidance and support. Hot lunches and supper were served and there was always a choice of yoghurts, fruit and ice-cream. We saw the snacks trolley on the ward in the afternoon.
- Results from the patient-led assessment of the care environment (PLACE) survey showed the trust, as a whole, scored below the England average for food.
- We did not see any evidence the ward was using an evidence-based paediatric assessment tool for assessing nutrition and hydration. However the executive team told us children were weighed on assessment and considered alongside age and weight to identify if they are underweight.

Patient outcomes

- There had been issues getting discharge summaries from orthopaedics and some urology clinics. This meant that if the child returned to their GP or A&E, no-one would be aware of the information from these departments. This issue has been escalated.
- The emergency department produced guidance for staff about caring for children with autism in an emergency department setting.
- The multiple admission rates for children aged between 1 and 17 with asthma was lower than the England average.
- The multiple admission rates for children aged between 1 and 17 with diabetes were higher than the England average. Statistics showed the trust was not as good at treating diabetes when compared to the England averages, however there had been recent improvements.
- Emergency readmissions for non-elective paediatric medical oncology were higher than the England average.
- Emergency readmissions within two days of discharge were lower than the England average for non-elective patients.

Services for children and young people

Competent staff

- Staff had an annual appraisal when a personal development plan was completed, identifying individual pathways for the individual.
- Nursing staff told us about a preceptorship scheme in place for their first year in post. This included courses on teamwork, medicine management and communication. Staff we spoke with were able to tell us what their induction had covered and what support they received.
- Agency nursing staff were provided with a 'mini induction' to give them enough information to be able to provide appropriate care and their PIN numbers were checked.
- We found staff were supported by regular reviews once they had completed their probationary periods and were provided with a mentor. All nursing staff, healthcare assistants and ward administrators completed a Performance Development Review (PDR) with a paediatric practice development nurse. If poor or variable performance were identified this was managed in line with the trust's policy and with support from the HR department.
- Although some senior staff had Advanced Paediatric Life Support training, they were not always on duty. Four members of staff were booked to complete Paediatric Intermediate Life Support training in April. There was always a paediatric doctor available on site. There were plans to train all band 7 nurses subject to funding approval.
- Staff knew which training courses they were going to attend and when the courses were running.
- Senior nursing staff were clear about the competencies nursing staff needed to be able to care for patients with high dependency needs. When staff did not have the competencies required, for example, using specialist equipment for respiratory failure, patients were transferred to other hospitals where the necessary resources were available.
- The radiology department did not have a radiographer with paediatric training. A new radiographer with paediatric training and experience had recently been engaged though a start date had not been agreed at the time of our inspection.

Multidisciplinary working

- There were limited services for children who required occupational therapy or physiotherapy services. Physiotherapy was provided for children with respiratory needs, or those who needed to use crutches. Staff said, "We're not funded for anything else." Staff told us that a paediatric speech and language therapist could be sourced via the community resources if necessary.
- A consultant psychologist was available if necessary. This would be arranged via Child and Adolescent Mental Health Services (CAMHS).
- There was no paediatric speech and language therapist or physiotherapist available.
- Where necessary, children or families requiring additional support were referred to social services.

Seven-day services

- Paediatric registrars were available on-call 24 hours a day, seven days a week.
- Staff told us they had access to everything they needed seven days a week. This meant out of hours imaging and pharmacy were available when needed.

Access to information

- When patients were discharged, their GPs were informed via Medway (the unitary authority providing all local government services). The system was not working on the day of our inspection, so paper copies were sent to GPs, health visitors, parents and the records department.
- A pack containing information about the process for when a child dies was available for all staff on each ward.
- A wide range of information was readily available for staff in folders. This included information about safeguarding and child protection, a resource folder for risk assessments, including slips and falls. The current moving and handling policy was also available. Other information available included NICE guidelines and incident reports with learning identified.

Consent

- Doctors obtained verbal consent. While staff we spoke with were aware of the need to obtain consent; they were not aware of the ward's policy for consent. Staff told us that if a child wanted to speak with a clinician without their parents they would be able to do so,

however, ward rounds were normally completed when parents were present. Staff told us they were not aware of a policy giving them guidance about what to do if a child did not want their parent to know something.

Are services for children and young people caring?

Good

We saw patients were treated with compassion and respect. All of the patients and parents we spoke with told us they were happy with the care provided by staff.

We saw staff explaining to patients and parents' the treatment and care planned. Children were involved in planning their care where possible. Parents were happy with the discharge planning in place.

Compassionate care

- A child friendly form of the NHS Friends and Family Test was used; this used a monkey theme to engage children. The result of the NHS Friends and Family Test was significantly better than the trust and national average at a 98% satisfaction rate. Things the ward could do better included listening to worries and fears so they could reassure people, making the ward as clean as possible and providing meals children were happier with.
- Interactions between staff and patients were very positive. If necessary, a nurse sat with a child till they fell asleep to prevent them becoming distressed.
- Parents and patients were very happy with the service and attention they received while staying on Clover Ward. Parents and patients we spoke with all told us staff were "kind and helpful", "all nurses are nice" and "everyone has been very helpful".
- Other parents said, "The staff are very nice," and, "I'm happy with the care provided."

Understanding and involvement of patients and those close to them

- One patient told us, "Nurses and doctors explain what's going on and I can ask questions if I want to know more."
- Parents told us they were involved in discharge planning. One parent told us, "I know when to expect my child home."
- One parent told us they were given open access to Clover Ward when their child was discharged, so they were able to return if they were concerned.
- Children were involved in planning their care with the use of timelines. This was a timetable where children were able to exercise choice. For example, they were able to decide when they preferred to take fortified drinks.
- One patient told us, "Doctors and nurses explain everything to me, what time my operation is and what they will do in the operation."
- Parents told us, "Staff have explained everything to me" and "I was given a recliner chair so I could stay overnight."
- One parent described their experience from A&E and transfer to Clover Ward and said, "From Triage onwards staff have been brilliant," and, "Every member of staff: consultant, nurses – everyone has been fantastic." Parents we spoke with told us doctors and nurses explained everything involved with their child's treatment and the management of their condition.

Emotional support

- Parents needing emotional support were supported through chaplaincy services.

Are services for children and young people responsive?

Requires improvement

The service children experienced during visits to the hospital for phlebotomy did not meet their needs.

There were limited resources available for children with mental health needs and no paediatric physiotherapist.

Children may be detained on the ward longer than necessary due to delays getting microbiology results.

Service planning and delivery to meet the needs of local people

- We found children under the age of three years were able to attend an appointment at Queen's Hospital for phlebotomy tests. However, children over the age of

three were seen in the phlebotomy clinic in the outpatient area of the hospital. As children were not given any priority, they may have waited several hours before being seen.

- We spoke with two mothers who both told us they had waited over two hours and they didn't know when they would be seen. Parents said, "It's a massive clinic, everyone just turns up and takes a ticket." The general waiting area was not child friendly as there were no play facilities for young children. We spoke with a phlebotomist who told us they weren't able to prioritise children unless they had special needs, when it was possible to make an appointment.
- In the phlebotomy area we found some toys were available, though some looked in poor condition and the range of toys was limited. Another phlebotomist told us they were not aware of any distraction methods to help with a child who became distressed other than using the available toys to distract them. They told us, "I see 100 plus patients a day and a significant proportion of these are children." The walls of one cubicle were decorated with child appropriate images.
- A cold spray was available to help numb the area to be used for blood collection.
- On the day of our visit, there were not enough chairs for everyone to be seated in the waiting area.
- There were limited resources available for children with mental health needs and limited access to child psychotherapy support.
- A number of staff of various grades, both doctors and nurses, were able to provide interpretation services in various languages. No leaflets in anything other than English were seen.
- To give families more choice the outpatients department adjacent to Clover Ward was opened in response to the high number of patients who did not attend appointments at Queen's Hospital.
- Staff told us children were able to be prioritised for ultrasound investigations.
- Two specialist nurses for diabetes were available. A specialist diabetes clinic was held once a week in the outpatient department adjoining Clover Ward.
- No paediatric intensive care unit was available on site. Children were sent to other hospitals if they need this level of care.

Access and flow

- There were delays getting microbiology results which meant children may stay in hospital longer than necessary.
- We spoke with theatre staff who told us that, when children required surgery, they were placed first on operating lists and they would only be sent for when theatre was ready. A paediatric nurse attended the child and one parent was able to stay with them until they were anaesthetised. The paediatric nurse attended recovery when the child was awake and accompanied them back to the ward. Distraction boxes were available to help ensure any distress was minimised, however, the reception area was stark and there was no distractions for children.

Meeting people's individual needs

- When children were ready to move to adult services we found this was done on an individual case by case basis. There was a transitional policy in place but staff did not refer to the policy an some were not aware of it.
- One parent we spoke with was unhappy with the out-of-hours service because they had made an appointment using the 111 service, but had to wait for one and a half hours to be seen. The parent said, "I had an appointment, I should not be kept waiting while my child was in pain." The out-of-hours department was near to the A&E department. The parent made the staff aware the child had not been seen for one and a half hours and they were seen by a doctor. The Royal College of Paediatrics and Child Health's (RCPCH) Standards for Children and Young People in Emergency Care Settings 2012 states that sick or injured children should receive an initial clinical assessment within 15 minutes of arrival. The parent said, "Once we were in A&E the care was good. Pain relief was given and we were seen by a surgeon and a paediatrician."
- There were no teaching facilities for long-term stay children of school age. Teaching services were removed because the hospital was deemed to be for short-stay patients. Staff told us, "Education is not managed for children who are in for longer periods of time," and, "We rely on parents to liaise with their child's school and the goodwill of that school," and, "Teachers from special needs schools have a good relationship with the ward and the children. They visit the children on the ward."
- Patient Group Directions (PGD) were not used. These are written directions allowing non-doctors including

pharmacists to assess patients and supply medicines without prescriptions, subject to exclusions. The use of PGD's can engage patients and provide choice in a monitored environment.

- A parent's room was available on Clover Ward where parents could make themselves a drink. The fridge was clean and food was labelled and dated. The room contained a communication board which gave information about the Patient Advice and Liaison Service (PALS) and chaplaincy. A notice board also gave information for parents about promoting healthy lifestyles, for example information was available about stopping smoking. A hand wash station was also available for the use of parents and siblings.
- A number of staff, both nurses and doctors, were able to provide translation services in a number of languages.
- A variety of national leaflets were available in the outpatients department which adjoined Clover Ward. The leaflets were well displayed and in good condition. However, they were not available in other languages and we did not see age appropriate leaflets available for children.
- Staff gave examples of the kind of adjustments they were able to make to be able to meet the needs of children with disabilities. An example they gave us was the use of sensory equipment and music for children who were not able to communicate but became distressed.

Learning from complaints and concerns

- Staff told us they received occasional informal complaints about the length of time children were kept waiting for anaesthetics. When this happened, staff responded by reminding the team that sent for the child to be mindful of the stress involved when children were kept waiting.
- Staff were able to give us examples of changes that had been made as a result of an informal complaint.
- According to the children's division governance report for February 2015, we saw that 94 PALS contacts, including 80 informal concerns and 11 compliments, had been received. Eighteen formal complaints were received since April 2014, and of those, 64% of complaints had been responded to within the required 25 day timeframe. Within this report, there was no reference to the themes of complaints. However, we found that the monthly complaints briefing paper to the trust board did identify reasons for delays in complaints and lessons learned, which was shared with the division. There was no evidence that this occurred in practice and, therefore, we could not be assured that learning from complaints was achieved consistently within the division.

Are services for children and young people well-led?

Requires improvement

There was no strategy in place to identify all the areas that required improvement so that high quality and safe care and treatment was consistently provided.

Paediatric services had a lack of developed governance systems which meant that risks were not always identified and escalated appropriately within the division to the patient safety team for appropriate management.

Staff told us positive changes had started to happen as a result of the new trust board. We were told of a number of new appointments to senior posts that had been made in the weeks preceding our inspection and those that would be made at the time of our inspection, which meant there would be a period of change for staff. Staff were positive about the culture within the unit and felt well supported and confident to raise concerns internally.

Discussions were ongoing with local commissioners regarding risks to the service, including the need for a designated high dependency unit and appropriate funding to provide the service.

Vision and strategy for this service

- Staff said, "We're not clear what they are, but we've had training on PRIDE and know what that is." Staff told us they "had no idea about the governance" of the hospital and said they don't see members of the trust's board.
- Matron told us, "Where we could get to has the potential to be phenomenal. You need that aspiration for your service."

Governance, risk management and quality measurement

- The divisional risk register had limited descriptions of controls and actions taken to address how these risks would be mitigated. Senior staff confirmed some of

these risks were no longer relevant and required reviewing but the lack of managerial governance support within the division had delayed this. Top risks described by senior staff were in line with concerns we heard about the services during our inspection, including the lack of HDU commissioned beds, the low number of neonatal nursing staff and lack of paediatric therapy provision. We also saw that some risks regarding children seen in other divisions were not shared, for example, there were adult orthodontic clinics being held in the paediatric area.

- Most staff were unable to describe what Duty of Candour was, however, staff generally felt the culture of the service was open and honest.
- However, we found a 'no harm' event where the family of the patient had not been informed at the time of the event. This was rectified and the family informed later.
- We saw minutes of the team meeting held in February 2015. The agenda covered a briefing for the team, an analysis of complaints and compliments and information about incidents. Other topics on the agenda included safeguarding, training and quality care.
- A review of the neonatal services across the trust was undertaken following safety concerns raised by clinical staff due to the lack of neonatal trained medical cover at night and weekends. The review resulted in the closure of all NICU cots at King George Hospital. Short and medium term recommendations had been implemented, though the demand on capacity remained a risk according to senior leaders.

Leadership of service

- The most senior paediatric nurse in the trust covered both sites, King George Hospital and Queen's Hospital.
- Staff we spoke with felt the matron for Children's and Young People's Services was courageous, compassionate and caring. Staff said, "Children are at the forefront of everything and matron is very supportive."
- Parents we spoke with said, "Everything is well planned, the routine and the information available."

Culture within the service

- We were told that concerns were raised by one member of staff about the culture within the organisation. The person concerned felt the trust responded appropriately, however we do not know the final outcome.

Innovation, improvement and sustainability

- The service developed an equivalent of the Paediatric Acuity and Nurse Dependency Assessment (PANDA) tool developed by Great Ormond Street Hospital (GOSH), which was used for scoring patients twice daily and to then calculate ward staffing levels.

End of life care

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

Information about the service

King George Hospital provided end of life care to patients with a progressive, life-limiting illness. Conditions included cancer, advanced organ failure, such as heart and renal failure and neurological conditions.

The specialist palliative care team was based at Queen's Hospital and worked across two hospitals managed by the trust. They provided support to patients and staff on all wards. This team also provided training to staff on the wards in various aspects of palliative care.

Between April 2013 and March 2014, the trust reported 1,143 patients' deaths taking place in both hospitals, with approximately 17% of them occurring at King George Hospital. The team received 1,527 referrals in the same period of time, these consisted of new patients, continuing patients and re-referrals to the service.

During our inspection, we spoke with patients and their relatives. We also spoke with 24 members of staff which included: the palliative care team, bereavement services, mortuary staff, chaplaincy, nursing staff, medical staff, Allied Health Professionals and porters.

Summary of findings

Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion. Specialist palliative care team members were visible, competent, and knowledgeable. Staff we spoke with were aware of how to report an incident or raise a concern.

Medicines were managed appropriately. Nurses were able to describe safeguarding procedures and how these were used to protect patients from abuse. There was a sufficient number of staff who received appropriate training. There were systems in place that helped to reduce inappropriate hospital readmissions and complaints were responded to appropriately.

There were systems in place for the routine monitoring of the quality of the service and the specialist palliative care team management had developed appropriate strategies and objectives to ensure continuous service improvement. Staff worked well as a team.

The hospital performed worse than the England average in the National Care of the Dying Audit. The trust's policy did not clearly specify in which cases staff were required to complete do not attempt cardio-pulmonary resuscitation (DNACPR) forms or how long after the admission they had to complete them. End of life services provided at the hospital were limited, with teams being based at another hospital managed by the trust.

End of life care

Are end of life care services safe?

Good

Information in relation to patient care and treatment was available to staff and records were adequately completed. Staff we spoke with were aware of how to report an incident or raise a concern. Appropriate equipment was available to patients at their end of life, most of the equipment at the hospital was adequately maintained. Medicines were managed appropriately.

Nurses were able to describe safeguarding procedures and provided us with examples of how these would be used. There was a sufficient number of staff who received appropriate training.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There have been no Never Events related to delivering end of life care.
- There were no serious incidents reported relating to end of life care in the hospital within the 12 months prior to the inspection.
- Staff we spoke with were aware of how to report an incident or raise a concern and gave us examples of how incidents were investigated and when they had received feedback.
- We observed all hospital deaths with palliative care team involvement were discussed at the specialist palliative care multidisciplinary meeting. A senior nurse told us feedback from mortality and morbidity meetings was received by the end of life committee group.

Cleanliness, infection control and hygiene

- We observed that the mortuary was well ventilated and free of odours. However, we noted that it was not clean throughout. The floor was stained and the fans in fridges were covered with dust. A member of staff told us that it was cleaned Monday to Friday, but there was no evidence of this cleaning taking place.
- The trust told us that since 2011, King George Hospital had not performed postmortem examinations, and the mortuary was used as body store only. It was not licensed by the Human Tissue Authority (HTA) and had not required a HTA inspection.

Environment and equipment

- Equipment, such as commodes, bedpans and urinals, was readily available to patients at their end of life throughout the hospital. Staff told us syringe drivers were used to give a continuous dose of painkillers and other medicines were available to help with symptom control in a timely manner.
- Patients were equipped with call bells in order to attract the attention of a member of staff when necessary.
- The mortuary was secure and access was partly controlled; only staff in possession of a magnetic key fob could enter it. However, key fobs did not enable the trust to trace who had accessed these premises and at what time. Staff were not required to sign in or out and there was no other monitoring system in place to ensure only authorised people accessed the hospital mortuary.
- We noted that lifting equipment, such as trollies used for bodies transfer was not suitably certified and checked, as required by the health and safety law. These checks are necessary to verify that the lifting equipment can continue to be safely used. The refrigeration systems were regularly maintained by external contractors.
- There were specific facilities available in the mortuary to store bodies long term. Staff told us these facilities were sufficient.

Medicines

- Medicines were stored safely. The trust did audits every three months to check medicines were stored appropriately and securely.
- Controlled drugs were managed appropriately. The trust did three monthly audits, which were reviewed by the safe medicines practice group.
- Doctors and nurses used a "net safety protocol" for prescribing and administering use of pain control medicines to prevent adverse drug events.

Records

- We were told the trust carried out an annual audit of do not attempt cardio-pulmonary resuscitation (DNA CPR)

forms, however, we noted that the audit did not include King George Hospital. We were unable to confirm there was an effective monitoring system in place to ensure forms were completed adequately.
- We reviewed DNA CPR forms. These, when put in place, were fully completed. They contained information such as who had approved the final decision and who was consulted in the process of a decision being made.
- We observed that DNA CPR forms were filed in patients' notes for easy access.
- Risk assessment forms were completed and easily accessible. They included falls and skin integrity risk assessments.
- The mortuary records, which included body release forms, were accurate.

Safeguarding

- Eighty-nine per cent of the specialist palliative care team members had completed level 2 safeguarding training for adults and children, against a trust target of 85%. This mandatory training was to be completed every three years. Administrative support staff were required to complete level 1 training, but only two of them (out of three) had up-to-date safeguarding training for adults and one for children.
- Nurses were able to describe safeguarding procedures and provided us with examples of how these would be applied.

Mandatory training

- The specialist palliative care team members said they had completed mandatory training, which included fire safety, basic life support, moving and handling and safeguarding adults and children. Training summary records were reviewed regularly to indicate how many of them had completed this training and when.
- The trust set a target of 85% of staff having completed mandatory training, when required.
- We noted that 95% of the specialist palliative care team (SPCT) members had undertaken up-to-date information governance training. Eighty-two per cent of the clinical staff working for the SPCT had completed training on preventing and responding to sepsis (a potentially life-threatening condition triggered by an infection) and the same percentage on health and safety and infection control.
- Ninety-one per cent of the specialist palliative care team members had undertaken fire safety training in 2014.

Assessing and responding to patient risk

- Patients had easy access to call bells and we observed their calls were responded to promptly.
- Staff had received training in basic life support. There was standard emergency equipment available to support patients in an emergency.
- The results of the National Care of the Dying Audit, published in May 2014, showed that 96% of patients had been recognised as dying and at the end of their lives, this was much better than the England average of 61%. The hospital also scored better than the national average for those patients who had been assessed within their last 24 hours, with 91% compared to the England average of 82%.
- There was a chart in use to record inpatient observations, such as pulse, blood pressure and temperature at the bedside and staff calculated an early warning score for each patient. It was used to alert staff to patients who may be deteriorating.

Nursing staffing

- The trust's specialist palliative care team consisted of a lead nurse for palliative care and seven (5.8 whole time equivalent) palliative care clinical nurse specialists. There were two end of life facilitators who supported staff on wards with training. The team was also supported by an occupational therapist and four administrative staff. Although this seemed sufficient to provide daily support to patients at their end of life across the trust. We noted that there was only one palliative care nurse working at King George Hospital. Nurses told us that there was a rotational rota in place with a member of staff allocated to the hospital each month.
- The sickness rate among the palliative care team members was, at 2% from August 2014 to January 2015, better than the trust average sickness rate of 3%.

Medical staffing

- There were three part time working palliative care consultants, a part time locum consultant, and a part time associate specialist doctor which represented a 2.4 whole time equivalent (WTE). This was not in line with the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance, which states there should be a minimum of one consultant per 250 beds.

End of life care

- The palliative care team had recognised that there was a need to increase medical staffing to improve services and this was documented in the team's strategy. Although no deadline was given, there were plans to present a business case for further consultant sessions.
- There was weekend and out-of-hours on-call advice provided by a consultant employed by the local hospice.

Major incident awareness and training

- The trust had developed an emergency and major incident plan in August 2013. It described emergency roles and procedures and how to manage an incident.

Are end of life care services effective?

Requires improvement

The hospital performed worse than the England average in seven out of ten clinical key performance indicators of the National Care of the Dying Audit relating to patient outcomes. The audit also indicated that only 35% of patients' hydration requirements had been reviewed, which was worse that the England average.

The trust's policy did not clearly specify in which cases staff were required to complete DNA CPR forms and how long after the admission they had to complete it. End of life services provided at the hospital were limited, with teams being based at another hospital managed by the trust.

Patients had appropriate access to pain relief. Specialist palliative care team members were competent and knowledgeable and there were good examples of the multidisciplinary team working.

The specialist palliative care team was available Monday to Friday, from 9am to 5pm. There was one specialist nurse working during Saturday and Sunday across two hospitals from 8am to 4pm. Out-of-hours, on-call support was provided by consultants.

Evidence-based care and treatment

- The specialist palliative care team told us that, following the withdrawal of the Liverpool Care Pathway, an individual care planning toolkit was introduced alongside the Gold Standards Framework for end of life care, which incorporated the Department of Health end of life care strategy, and aimed to support staff with identifying patients' preferences and wishes earlier in their disease trajectories in order for improved advance care planning to take place.
- The trust's DNA CPR policy was due to be updated in January 2015. We were presented with an updated version of the policy, which was awaiting final ratification. Although it had been developed in line with the Resuscitation Council (UK) framework and The Association of Anaesthetists and General Medical Council's guidance, it only partially addressed issues related to the DNA CPR form.
- The trust had a standard DNA CPR form, which staff were required to complete and place in the front page of the patient's notes. The supporting policy did not clearly specify in which cases staff were required to complete the form and how long after the admission they had to complete it.
- The end of life committee had drawn up an action plan in response to the NICE palliative care guidance and National End of Life Care Strategy to ensure that the trust had a clear action plan, highlighting the progress against each agreed action. Progress against this plan was monitored, with target dates allocated to each of the actions listed.
- The trust had a formulary, which listed medications the pharmacy stocked with guidance on prescribing these. This was used to promote rational, cost effective prescribing and any amendments to the formulary had to be approved by the drug and therapeutics committee. We saw that this formulary, along with the trust antimicrobial prescribing guidelines, were easily accessible to all staff via the trust intranet.

Pain relief

- Patients told us they had access to pain-controlling medication whenever required.
- The pain teams provided services five days a week, due to staff shortage. There were two specialist pain teams, which worked under the anaesthetic directorate across the two hospitals managed by the trust. It included the acute and chronic pain teams which were based at Queen's hospital. The acute pain team supported patients who did not meet the criteria for specialist palliative care.
- The hospital's results from the National Care of the Dying Audit for hospitals, showed that, at the time of the

patients' death, there was documented evidence that 'use when required' medication had been prescribed for 48% of patients, this was slightly worse than the England average of 51%.
- The bereavement survey completed by the trust between September 2013 and August 2014 indicated that pain support was adequate with 96% of patients stating that they received adequate support if required. For those that answered the question in the last two days of life, 75% described pain control as being 'good' or 'excellent'. This was in line with the national average when compared with the National Survey of Bereaved People (VOICES), 2013.

Nutrition and hydration

- The National Care of the Dying Audit found that 35% of patients had a review of their nutritional requirements, this was worse than the England average of 41%. Only 35% of patients' hydration requirements had been reviewed, which was worse that the England average of 50%.
- Forty-eight per cent of relatives reported via the bereavement survey that the help given to their relative was 'excellent' or 'good', 52% said it was 'fair' or 'poor'. This survey was completed between September 2013 and August 2014.
- Most patients we spoke with were happy with the food and drink provided by the hospital. They had access to drinks that were within their reach. We observed nutritional assessments were completed and that nursing records, such as nutrition and fluid charts were completed accurately. We saw that menus catered for cultural preferences.

Patient outcomes

- The hospital scored in line with the England average, or better in all organisational key performance indicators of the National Care of the Dying Audit for 2013/2014. However, three out of seven indicators were not achieved. In addition, the hospital performed worse than the England average in seven out of ten of the clinical key performance indicators relating to patient outcomes.
- A trust bereavement questionnaire for 2013, which aimed to obtain the experiences of people who had died, suggested that end of life care provided at the hospital was 'good' or 'excellent' and that doctors and nurses had demonstrated a standard of care that promoted respect and dignity.

Competent staff

- Seventy-three per cent of the palliative care team members had been appraised within the 12 months prior to the inspection.
- There was one bereavement officer working at the hospital who had received minimal training. Other administrative staff supporting the specialist palliative care team had not been provided with all mandatory training and two had not been appraised within the 12 months prior to the inspection.
- Although we noted the specialist palliative care team members had attended training relevant to their role, the trust did not provide all clinical staff with training in end of life care, as recommended by national guidance.
- The trust did not routinely monitor who had received syringe driver training and there was no training log kept by the pain team, or the specialist palliative care team. We were told that the specialist palliative care team provided training on an individual basis "when needed for clinical areas".

Multidisciplinary working

- The multidisciplinary team work was well embedded in clinical practice. There were weekly multidisciplinary team meetings to discuss individual patient pathways and their clinical needs. We observed that a holistic approach to care was taken and that issues discussed at those meetings included meeting patients' physical, psychological, social and spiritual needs.
- There was a social worker, occupational therapist and discharge coordinator allocated to the specialist palliative care team. We observed that they participated in weekly multidisciplinary team meetings.
- Patients' records included entries made by Allied Health Professionals, doctors and nurses. Speech and language therapy and dietician advice was also routinely obtained. Patients were supported by the occupational therapist when required.

Seven-day services

- The specialist palliative care team was available Monday to Friday, from 9am to 5pm. There was one specialist nurse working during Saturday and Sunday across two

hospitals from 8am to 4pm. Out-of-hours, on-call support was provided by number of the consultants on a rotation basis, it included those at the local hospice. The palliative care team was planning to recruit additional staff with an aim to increase staff availability during weekends.

- There was an identified bereavement officer available Monday to Friday. There was no seven-day support for families for issuing death certificates. The services provided by the pain team had been reduced in 2015 from seven to five days a week, due to staff shortages. A nurse told us that they felt the senior management team had failed to address the issue by not recruiting new staff or providing cover for vacant shifts.
- The mortuary team was based at the Queen's Hospital, they were available at King George Hospital only when an appointment had been made. There were arrangements and a procedure to allow bodies to be released out of hours and during the weekend.
- There was no routinely accessible pastoral care support provided at the hospital. The team was based at Queen's Hospital and visited King George Hospital at patient or staff request. A chaplain told us that a member of the team visited the hospital two or three times a week.

Access to information

- All DNA CPR forms were filed in patient notes and were easily available to staff.
- Nurses and doctors told us they felt they had sufficient access to information in order to support clinical decision making.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- In all cases, DNA CPR forms were signed by an appropriately senior clinician. Patients' views relating to resuscitation were clearly recorded in their notes and on the form. However, it was not routinely noted or monitored whether the patients' capacity to make and communicate decisions had been assessed. It was not indicated on the DNA CPR form. The new form, which prompted staff to indicate it, and a policy addressing the issue, was awaiting a sign off at the time of inspection. The hospital had an online training program on DNA CPR ready to roll out for all staff.
- Staff were provided with appropriate guidance on the actions they should take if they were unclear if a patient had the capacity to consent. This included contacting relatives or friends and checking whether patients had made a lasting power of attorney related to health and welfare.
- We observed that nurses were aware of how to initiate Deprivation of Liberty Safeguards and referrals were made appropriately. They also sought urgent authorisation whenever it was required.

Are end of life care services caring?

Good

Patients were involved in care planning and decision making. Staff were respectful and polite and treated patients with compassion. They maintained patients' dignity and provided patients with adequate emotional support.

Compassionate care

- There was a bereavement questionnaire completed between September 2013 and August 2014. The questionnaire was sent out six to eight weeks after an adult death within the trust, and asked respondents to report their experience of the end of life care, with particular emphasis on the care received in the last two days of life.
- The trust had sent out 1,294 questionnaires to service users, 436 completed questionnaires (33%) were returned. Seventy-seven per cent of respondents replied that doctors gave 'good' or 'excellent' care. The same number reported that nurses gave 'good' or 'excellent' care. Sixty-four per cent of patients said their relative had been treated with respect and dignity at all times, with 3% saying that their relative had not been treated with respect or dignity.
- Sixty-seven per cent of patients 'strongly agreed', or 'agreed' with the statement that there had been "enough help with personal care". This was worse than the national average of 72% taken from the National Survey of Bereaved People (VOICES).
- Seventy-two per cent of patients 'strongly agreed' or 'agreed' that there had been enough help with nursing care. This was in line with the national average of 73%.

End of life care

- We observed patients being treated with compassion, dignity and respect. Nursing staff were polite, explaining procedures in simple language and answering patients' questions.
- Porters told us staff in clinical areas and mortuary staff handled bodies in a respectful way.

Understanding and involvement of patients and those close to them

- Staff provided patients with information on how to contact the palliative care team and where to obtain additional support and information. Patients said they felt involved in their treatment and that staff explained each of the stages and optional treatments available to them.
- Nurses explained to patients about their medicines and encouraged them to take them.
- Patients' wishes regarding end of life care and preferred place of death were clearly recorded in patients' notes and staff were aware of it.
- The bereavement survey indicated that there had been enough communication from ward staff, with 62% agreeing to this statement. However, 14% of the bereaved families 'strongly disagreed' with this statement.

Emotional support

- There was a bereavement office, which issued death certificates and provided relatives with information on support services available to them, and what to do following a death.
- Chaplaincy services were available on request. A chaplaincy team member told us that they were able to offer spiritual support to patients of all or no faiths as they had developed close links with local churches and members of various congregations.
- Once a month, there was a coffee morning organised by the specialist palliative care team in the local YMCA, it was run and directed by a senior team member. It was a session where the bereaved were able to share their experiences and to support each other through their loss.
- Sixty per cent of relatives reported, via the bereavement survey completed between September 2013 and August 2014, that the psychological support offered to their relative was 'excellent' or 'good'. Forty per cent said it was 'fair' or 'poor'.
- In answer to the question "Was there enough support for the family at the time of death?" Eighty per cent said 'definitely yes' or 'to some extent', with 20% saying 'no' or 'not at all'. This was slightly worse when compared with the National Survey of Bereaved People (VOICES).
- Ninety-five per cent 'strongly agreed' or 'agreed' they had been given enough time to sit with the deceased on the ward. Only 1% 'strongly disagreed' or 'disagreed' with this statement. Seventy-two per cent of the people who responded to the survey recalled being told that they could view the body of the deceased. Ninety-two per cent remembered being given the bereavement information booklet and the same number said staff had been sensitive in dealing with them in bereavement.

Are end of life care services responsive?

Good

Patients had adequate access to the specialist palliative care team and staff were able to identify those who needed the service. There was specialist support available 24 hours a day, specialist palliative care team members were visible and staff knew how to contact them.

There were systems in place which helped to reduce inappropriate hospital readmissions. Complaints were responded to promptly and actions had been taken in response.

Service planning and delivery to meet the needs of local people

- The trust had piloted two electronic palliative care planning systems that aimed to provide a cross-boundary service for patients and their relatives. Its purpose was to improve communication across multiple care providers. The team were monitoring issues and evaluating how many patients died in their preferred place of care.
- We were told that pilots had been delayed in starting, due to technical difficulties with the computer programs and the fact that the trust was relying on the commissioning group to take a decision on which system was to be used.
- The hospital used Proactive Elderly Advance Care (PEACE) planning tool to improve communication in the

transfer of clinical information between hospital and care home or other community care settings. This helped to provide an individualised document that recorded the suggested action plans on the progression of illness, which had been discussed with patients, relatives and carers. A lead nurse told us it helped to reduce inappropriate hospital readmissions.
- Most patients at the end of their life were cared for in the main ward areas and there were no specifically designated palliative care beds at the hospital.
- The specialist palliative care team worked in partnership with a local hospice to ensure support was available 24 hours a day.

Meeting people's individual needs

- There were a limited number of single rooms available to patients in the final days and hours of their lives. Frequently, patients were cared for in shared rooms.
- The specialist palliative care team were responsible for arrangements for rapid discharge to ensure patients at end of life died at their preferred place. In October 2013, the average time from decision to case closure was 12 days, in cases where external funding was needed. This had reduced to an average of 5.5 days since October 2014, as all fast-track applications were approved within 48 hours by the local brokerage team. The team worked to reduce the time from decision to case closure to four days.
- Staff told us translation services were available and, generally, there were no delays in accessing them when required.
- There was printed information available for patients and their relatives, including leaflets on what they needed to do after their relative died, as well as the emotional support available. This information was only available in English.
- The National Care of the Dying Audit for hospitals in England (2013/14) found that 35% of patients had a spiritual needs assessment at the hospital, which was slightly worse than the England average of 37%.
- Mortuary viewing facilities were appropriate and allowed relatives privacy.
- There was no operational procedure for the management of deceased patients' belongings. Usually, patient's belongings were left behind on the ward and locked away in the nurses' office until they were collected by the nominated relative.
- The National Care of the Dying Audit found that, in only 22% of all cases, a review of the care after death was undertaken. This was worse than the England average of 59%.

Access and flow

- The specialist palliative care team, which worked across two hospitals managed by the trust, received 1,527 referrals in 2013/14. Those were new patients, continuing patients and re-referrals to the service. The team predominantly saw patients as inpatients but also run an outpatient service and provided telephone advice when needed.
- There was a clear standard set for allocating patients to the specialist palliative care team and who could refer a patient and how. The team used advance care planning to reduce inappropriate readmissions at end of life.
- Nurses told us that specialist palliative care team members were visible and all staff we spoke with knew how to contact them.
- Doctors and nurses told us they had access to diagnostics and test results promptly.
- There was a fast-track discharge system to ensure patients who were in the last days and hours of life could die in their preferred place. The trust monitored response times to identify if there were any obstacles to discharge for patients, so that staff could work to ensure patients died in their preferred location.

Learning from complaints and concerns

- The hospital's end of life committee was involved with reviewing complaints reports and clinical incidents.
- The specialist palliative care team had received one complaint in 2014 relating to end of life services. It had been responded to promptly and appropriate actions had been taken in response, which included sharing learning at the clinical governance meeting.
- Information on how to raise concerns, or make a formal complaint was displayed on individual wards. The trust had a policy, which set out how complaints should be dealt with, as well as the timescales for responding to them.

End of life care

Are end of life care services well-led?

Good

There was a five-year vision developed by the trust's end of life care committee.

There were systems for routine monitoring of the quality of the service across the hospital. The specialist palliative care team were aware of issues relating to their specialties and had developed appropriate strategies and objectives to ensure continuous service improvement.

Staff worked well as a team.

Vision and strategy for this service

- There was a five-year vision developed by the trust's end of life care committee to "ensure people approaching the end of life receive care tailored to their needs, delivered by staff that are knowledgeable and compassionate, in surroundings that provide comfort and dignity in partnership with communities". We were told that the main focus for the specialist palliative care team was to get patients at their end of life to their preferred place of care and death.
- Staff we spoke with were aware of the generic corporate objectives set for 2014/15, which focused on improving care, staff retention and engagement, and improving the financial stability of the trust.
- The trust's five-year forward view strategy document was published in December 2013, with a view to improving the service for the local population, focusing on patient-centred care and encouraging staff to "take pride in [the] care" provided.
- The trust have developed a set of behavioural values, working with "Passion, Responsibility, Innovation, Drive and Empowerment", summarised as taking 'PRIDE'.
- We noted that 86% of the specialist palliative care team had received PRIDE training in 2014.
- The end of life committee had drawn up an action plan in response to the national strategy and guidance to ensure that the trust had a clear action plan highlighting the progress against each requirement. Progress against this plan was monitored, with target dates allocated to each of the actions listed.
- There were 'key current priorities' clearly set for the specialist palliative care team, which included implementation of the new individualised end of life care plan across the trust, service development towards inpatient palliative care beds, an increased specialist palliative care workforce, rolling out the Gold Standard Framework for end of life care and decreasing the time taken to 'fast-track' patients out of hospital at the end of life.

Governance, risk management and quality measurement

- The trust had an end of life committee chaired by the director of nursing. This group met regularly with an aim to improve end of life care for patients dying in the hospital. The director of nursing was the allocated executive lead responsible for overseeing the delivery of the end of life service across the trust.
- Staff were clear about the role of the senior responsible clinician in specialist palliative care and their involvement in decision making.
- There were no specific risks indicated on the trust's risk register relating to end of life care or the specialist palliative care team.
- The Commissioning for Quality and Innovation (CQUIN) payment framework targets for 2013/14 relating to end of life care included: implementation of the Liverpool Care Pathway to review findings, a training programme for all senior clinical staff, sharing findings of the review with a focus on nutrition and hydration, advocacy, accountability, and syringe drivers, end of life medication, sedation and pain relief, continuous monitoring of fast-track discharge home for palliative patients, training for staff on twenty wards to increase staff awareness relating to the 'preferred place of care' and the provision of a seven-day, face-to-face service.
- Sixty-five consultants had attended a half-day seminar teaching session in end of life care and the trust had achieved its targets and reported that audits showed an improvement in consultant communication for patients at the end of life and medication prescribing. This included an increase in consultant-led end of life discussions about nutrition and hydration. In addition, documentation of preferred place of care had increased by 21%.

Leadership of service

- The team leader for specialist palliative care and the clinical lead for the service were aware of issues relating to their specialties and had developed appropriate

strategies and objectives to ensure continuous service improvement. There were systems in place to ensure this was communicated to all staff caring for patients at the end of their life. For example, there were end of life information boards on each of the wards containing information related to end of life principles and on recent developments within the area.
- There was good coordination across all divisions to ensure consistency of approach and that end of life training, when provided, was cascaded to all appropriate staff.

Culture within the service

- We observed that the specialist palliative care team worked well together. They spoke about supporting each other with workload and day-to-day work whenever required. Staff were focused on providing patients with the "best possible outcomes". They told us they aimed to provide "patient-centred care".
- Specialist palliative care team members felt encouraged by their immediate line managers to report any concerns they had and felt they could discuss any issues with their manager.
- The senior leaders told us they aimed to maximise staff involvement in all decisions made so they could own the changes made and help them to improve the service.
- The chief executive told us that they felt staff were very passionate and that the trust focused on enabling them "to do what they do best", which was providing compassionate care at the patient's bedside.

Public and staff engagement

- The trust organised a bereaved families survey across 2013 and 2014 to gather relatives' views relating to end of life care received by the patients who died at the hospital. The response rate to this survey was low (35%) and findings, although positive, were not fully representative. Overall, families and carers stated that end of life care was 'good' or 'excellent', doctors and nurses had shown the patient and their relatives respect and dignity. The results also indicated that communication, advance care planning and symptom management needed to be improved.
- The trust had organised a 'dying awareness week' in May 2014 , which was held within the main atrium of the hospital with a view to engage the public as well as healthcare professionals. Discussions about wills, registering for organ donation and planning future care and support were held with staff who could provide advice on the subject.
- We were told that staff engagement with end of life care had improved in the months leading up to our inspection. Nurses and doctors were aware of the end of life committee, they were also aware of the resources available to them, such as an "end of life box" provided by the specialist palliative care team equipped with leaflets and information related to the subject. The trust had started to provide end of life training and this was well publicised for staff working on individual wards.

Innovation, improvement and sustainability

- The trust was in the process of preparing long-term strategies for the specialist palliative care team and end of life care to ensure service sustainability.

Outpatients and diagnostic imaging

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

Information about the service

In 2014, the trust outpatient department (OPD) clinics accommodated 591,602 outpatient appointments. Of these, 187,919 were new outpatient appointments, and the remaining 403,683 were follow-up appointments. King George Hospital OPD saw 159,856 of these patients.

In 2014, the trust had completed just over 38,000 computerised tomography (CT) scans, nearly 25,000 magnetic resonance imaging (MRI) scans, just under 70,000 ultrasound scans and approximately 6,000 nuclear medicine scans.

The main OPD was situated off of the entrance lobby of the hospital. The phlebotomy clinic was located directly inside the entrance. Behind the phlebotomy area sat OPD bases two and three, beside base three was the ambulance pick-up point for patients who required hospital transport.

There were separate OPD areas for physiotherapy and rheumatology, chest and respiratory clinics. Cardiology was located on the first floor. The call centre and choose and book office were located at the King George Hospital site but covered both hospital sites.

King George Hospital ran clinics in general surgery, ear, nose and throat (ENT), breast surgery, cardiology, nephrology, respiratory medicine, neurology, orthopaedics, trauma, urology, opthalmology, clinical oncology, endocrinology, rheumatology, gastroenterology, general medicine, anti-coagulation, pain management, and dermatology. Paediatrics is reported in detail within the paediatric section of this report.

As part of this inspection, we visited most OPD and diagnostic areas at the hospital site. We spoke with 27 patients and relatives. We also spoke with 43 staff, including departmental managers. Information provided by the trust was reviewed and corroborated for accuracy and then used to inform our judgement.

Outpatients and diagnostic imaging

Summary of findings

Staff were not always reporting safety incidents.

The trust had stopped reporting referral-to-treatment (RTT) waiting times from September 2014 and was unable to evidence compliance with clinical commissioning group regulations.

The phlebotomy clinic was overstretched, with long waiting times and there was no capacity to prioritise fasting patients or children. Seating areas were cramped and the department was unable to seat all the patients waiting in the clinic. Patients attending the phlebotomy clinic had a particularly poor patient experience. Staff did not have an overview of the waiting area and patients were unable to ask for assistance when required.

There was a significant backlog in the reporting of x-rays and 15% of patient appointments were cancelled in 2013/14. Patient health records were not always available at clinics and the hospital used a high number of temporary health records.

Staff had failed to ensure that resuscitation equipment was checked and fit for purpose. We also found medications stored in the department, which had passed their expiry date.

Radiology and haematology were struggling to meet with the demands on the service, due to a lack of suitably qualified staff.

Are outpatient and diagnostic imaging services safe?

Inadequate

Staff were not always reporting incidents. When incidents were reported, staff did not consistently receive feedback.

Staff had not checked resuscitation equipment. We found trollies with inappropriate and missing equipment in some areas of OPD.

Stored medicines had passed their expiry date, which meant that the department did not have adequate systems in place to check that drugs being stored in the department were fit for use.

Patients in the phlebotomy area could not be seen by phlebotomy or nursing staff. Patients taken unwell in this area would depend on other patients or members of the public to alert staff.

Radiology and haematology were struggling to meet with the demands on the service, due to a lack of suitably qualified staff.

Incidents

- During 2014, there had been no serious incidents reported in OPD and three serious incidents reported in radiology across the trust.
- Radiology had six serious incidents still being investigated at the time of our inspection. The reporting on five of these serious incidents was overdue and had not met the trust's 45-day incident investigation criteria.
- Policy stated that incidents should be reported through a system that enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- Staff completed an incident form, which, once submitted, went to their line manager who reviewed it and reported on the actions taken to mitigate a recurrence of the incident.
- At King George Hospital there had been 25 incidents reported by staff working in OPD during December 2014. Ten of these incidents related to patient health records. These were mostly issues around incomplete records or

incorrect patient information being filed into health records. Two incidents related to a lack of clinicians in clinics and three were related to appointment or referral issues.

- Across the trust, 35 laboratory incidents were reported in December 2014.
- Incidents were discussed at the pathology directorate meeting along with learning from these incidents and improvements made to the service to mitigate the chance of recurrences of incidents, where possible.
- The radiology department had reported 140 incidents between September 2014 and February 2015 across the trust. Incidents reported were from a mixed range. The most prevalent being for problems with diagnostic tests and a failure to x-ray.
- OPD managers told us they reported back to staff following an incident during daily staff meetings. We looked at the minutes of these meetings and noted that incidents had been discussed. Some staff also told us they received feedback from incidents during their daily department huddles. However, other staff told us they saw no point in reporting incidents as they didn't feel that systems or practice changed as a result.
- Managers told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.
- The matron told us getting staff to complete incident forms was a "constant battle". They said, "I am constantly reminding staff about how important it is to complete incident forms". They said they thought one of the reasons staff did not complete online incident forms was that the terminals were constantly being used during clinic, and staff were very busy. When it got to the end of clinic and staff had the time and access to a terminal the moment had passed and staff forgot.

Cleanliness, infection control and hygiene

- There were hand hygiene 'bare below the elbow' audits undertaken, which demonstrated that staff were compliant with best practice guidance. These were done for each OPD area, and documented in the annual clinical governance report. The staff we observed in the OPD were complying with the trust's policies and guidance on the use of personal protective equipment and were bare below the elbows. We observed staff washing their hands in accordance with the published guidance.
- Staff working in the OPD had a good understanding of their responsibilities in relation to cleaning and infection prevention and control. Outpatient treatment rooms were clean, with the exception of computer keyboards, which were dusty.
- Toilets were cleaned twice each day and checked a further two times. Signage told members of the public to use a telephone number to contact the cleaning help desk if they found the facilities did not meet cleanliness requirements at other times. We found the toilets to be below the required cleaning standards on four occasions during our inspection. When we called the helpdesk on one occasion to report the issue, a cleaner arrived 40 minutes later to rectify the issue.
- Clinical areas were monitored for cleanliness by the facilities team. Housekeeping staff could be called to carry out additional cleaning, where staff felt it was necessary. Cleaning audit scores met with expected cleaning standards, with audit scores ranging between 96% and 98%. Where areas were found to be below the expected cleaning standards during an audit, a recheck sheet was completed highlighting the area of concern. Cleaning staff were expected to correct the issue within 24 hours.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that equipment and rooms had been cleaned.
- Labels the trust used to indicate that equipment had been cleaned were mostly being used, although this was not consistent across all areas of OPD.
- Decontamination and environment checklists were used each morning by a designated nurse who ensured that the main OPD areas were cleaned.
- In the respiratory area of OPD we found that the dirty utility on a public corridor was unlocked, with the door left opened. This room contained cleaning fluids which should be stored securely, as required by legislation, as members of the public could access this area.

Environment and equipment

- We found that OPD had insufficient resuscitation equipment provision, with irregular or incomplete equipment checks, inappropriate equipment on one trolley, and variability in what equipment was in the department. Signage directing staff to where automated external defibrillators (AEDs) were located, was

inadequate. In the COPD/respiratory clinic an AED was stored with pads that were out-of-date. In the main OPD, we found that the emergency drug box, which should be stored with the resuscitation equipment, had been moved to another room. Staff were not able to give an explanation for this.

- In three areas, staff were unable to evidence that resuscitation checklists had been completed consistently. In one case, staff told us they did not have a checklist for their AED equipment saying that the only check was that staff "passed the equipment regularly and would cast an eye over it". When asked about issues with resuscitation equipment staff members offloaded responsibility for the equipment within their department. These staff were from different disciplines, but all felt that the responsibility for resuscitation equipment belonged to someone else. However, all of these staff acknowledged that if a patient collapsed in their department they had been trained to provide basic life support and would use the resuscitation equipment to do this.
- We spoke with the resuscitation lead about our concerns. They told us they audited resuscitation equipment annually and had reported to staff in the physiotherapy area two weeks previously that the resuscitation equipment was overstocked with unnecessary equipment. They said they had been given assurances that this would be corrected.
- In the physiotherapy area, we found incorrect recording of expiry dates of IV fluids on record sheets.
- There was no access to emergency oxygen for a patient using the treadmill during a stress test in the cardiac department. The staff members we spoke with were unable to access oxygen masks and tubing. Staff thought that this equipment was accessible in a drawer in the room, but on further examination found that it was not. They then told us equipment was in a cupboard further up the corridor.
- The staff in this department based their risk assessment on the relative infrequency of the treadmill being used, rather that acknowledging the fact that the activity was inherently high risk for patients. Equipment to administer oxygen in an emergency would have required the staff member to leave the room to get a mask. The rationale for this was that the mask and tubing would only gather dust if left attached to the oxygen cylinder.
- The clinical room in the main OPD was cluttered with equipment, such as trolleys for specimen pots, dressing trolleys, two examination trolleys, scales, automatic blood pressure and pulse oximeter equipment, as well as a resuscitation trolley.
- A toilet in the cardiology/respiratory OPD had been renovated to become a weight and clinical observation room for patients. The room did not have a privacy curtain across the front of it and faced onto the patient waiting area. The area was small, with no ventilation or natural light. Patient access was limited with inadequate space for patients requiring mobility aids.
- All mobile electrical equipment that we looked at had current portable appliance testing certification.
- The hospital had one CT scanner and one MRI scanner. The department had a radiation protection 'local rules' policy in place.

Medicines

- Medications were stored securely. However, some medicines stored in the department had passed their expiry date. Out-of-date medications included: atropine sulphate, adrenaline (2%), furosemide (50mg), chloramphenicol eye drops, and lignocaine. This meant that the department did not have adequate systems to check that drugs being stored in the department were needed, were within their expiry date, or were fit for use.
- We also found two 500ml bottles of methylated spirits in the medicines cupboard, which is a highly flammable liquid. When staff were asked they could not tell us how or why methylated spirits were used in the department. Legislation requires risks from the indoor storage of dangerous substances to be controlled by elimination, or by reducing the quantities of such substances in the workplace to a minimum and providing mitigation to protect against foreseeable incidents. It is the responsibility of the trust to carry out risk assessments, to justify the need to store any particular quantity of flammable liquid within a working area. However, the guiding principle is that only the minimum quantity needed for frequently occurring activities should be stored. As staff were unable to explain how the stored substances were used in the department, they were failing to meet with the requirements of this legislation.

- Refrigerator temperature checks were being completed by staff in line with policies. Temperature records that we looked at were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range.
- Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions the OPD kept a log, which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.
- Where staff had concerns about a prescription pad missing a sheet we saw that this had been raised and investigated through the incident reporting process.
- Patient leaflets relating to medications were available in each area of OPD.

Records

- A storage area that could be accessed by all staff members had filing cabinets, which were unlocked and contained archived staff files, which included personal staff details. Staff could access these files about colleagues, which meant that the department was not protecting their staff members' personal data.
- The filing cabinet also contained historical diaries and patient records. Although this area could only be accessed by staff, personal patient data should only be accessed by staff that needed to know the information in order to perform their roles. Therefore, the department had failed to protect patients' personal information.
- In the anticoagulant clinic, we found patient records on a trolley outside of a clinic room. A volunteer explained to us that they had left the information there for a short time while taking some information to another area of OPD. However, this was a public area easily accessible to patients and visitors.
- The treatment room would be used to take down wound dressings for wounds to be observed by the relevant doctor (or other clinician) and then redressed by the OPD staff. When this occurred, the record of treatment was recorded on a slip of paper, with a patient identifier, such as a hospital number along with a sticker with the patient's full demographic details. Some of the pages we observed had two patients details recorded on them. The information contained in the folder was a record of the dressing treatment received by the patient and the identity of the nurse who carried out the procedure.
- When asked why this information was not recorded in the patient's notes, we were told that the clinic doctor had all the notes to allow them to dictate patient letters at the end of clinic and so they did not have easy access to the patients' primary health records. The staff in the treatment room did not perceive any information about the governance problem with holding patient data in this form unsecured for an unspecified amount of time. Recording patient treatment in this way is not in line with the Caldicott Principles. Staff were unable to evidence any plan for the safe management of this information.
- Clinicians told us the availability of patient records was an issue. They told us every clinic ran with temporary sets of patient health records for some patients. They said that, although some diagnostic information and clinic letters were available on the computerised systems, health records were important for establishing a full patient history.

Safeguarding

- The OPD had a link nurse who had a special interest in safeguarding and shared relevant information and updates with the rest of the team.
- There was a safeguarding lead at the hospital and OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the trust's safeguarding lead was and how to contact them.
- Staff working in the OPD had completed mandatory safeguarding training to level 2, and child protection training to level 2. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust's safeguarding policies on the intranet.
- An OPD staff nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.

Mandatory training

- Staff mandatory training was evidenced by a paper-based table indicating that 100% of staff were up-to-date with mandatory training. The department manager stated that they preferred to rely on this data than that recorded on the trust's training management system as it was more up-to-date. It reflected staff that were on long-term sick leave or maternity leave as long term leave could skew the percentages for compliance.

Outpatients and diagnostic imaging

- Staff were given time to undertake mandatory training, which was offered as a two days of face-to-face training, augmented with e-learning. Some staff told us accessing e-learning had practical difficulties as it was located on the trust's intranet. Staff needed to access it through computers in the department, which was not always possible. However, staff did feel there was a "will" to let staff complete training within working hours.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the trust's policy.

Assessing and responding to patient risk

- The phlebotomy waiting area was unstaffed and, on each morning we inspected, this area was overcrowded with up to 27 patients having to stand throughout our visit. Chairs were in rows and patients struggled to get past each other to get out of the centre of the rows of seats. Should a patient become unwell in this area staff were dependent on other patients or members of the public highlighting this to them. Staff acknowledged that if a patient was taken unwell in the centre of the seating they would be unable to get a trolley to them and would struggle to treat them in the tight space available.
- Emergency bells in the main OPD were checked daily. Nurses completed checklists as evidence that this had been done. In the main OPD emergency bells were available in treatment rooms. The emergency bell in the phlebotomy clinic could not be heard in the sister's office. This could mean that patients in this area would not get the assistance they required promptly.
- Where patients required hospital admission from OPD they were looked after in the department until a bed on a ward became available. We were told that, occasionally, this could take some time and patients had still been waiting in the department in to the evening for a bed on a ward.
- The department had a protocol in place, which staff followed when a patient was taken unwell in the department.
- When patients became unwell staff would assess them using the National Early Warning Score (NEWS). If clinical need was identified as being necessary, patients would be transferred to the emergency department for treatment.
- Staff had received mandatory training in patient resuscitation and basic life support.

Nursing staffing

- The main OPD was fully staffed to establishment with nurses and rarely used bank staff. When bank staff were needed, regular staff were used so that they understood the nature of the work involved and had relevant competencies in place.
- The department had a band 8 matron, a band 7 sister, two band 6 junior sisters, 13 band 5 nurses and 25 band 2 healthcare assistants.
- The department used a staffing contingency plan to assess daily whether they had sufficient numbers of nursing staff in the department. The plan included a staff escalation protocol which instructed staff on procedures to follow when staffing levels fell below the level required to run the department safely.
- All of the staff that we spoke with felt that there were enough staff of a suitable skills mix to manage the workload.
- Where areas required a trained nurse to be available for clinics, for example, rheumatology clinics, they would be provided.

Medical staffing

- The MRI department had four radiographers, who covered the service from 7am until 8pm daily. Agency staff then covered the 8pm until 12pm shift as the department did not have enough radiographers to cover the service. The radiographers covered the hospital on an on-call basis overnight. Radiographers that we spoke with said that the rotas were unsafe as they were expected to work on call overnight and then work a long shift from 7am until 8pm the following day.
- Staff were concerned about the numbers of CT trained staff working in the department. Three members of staff were on long-term sick leave at the time of our inspection. Staff told us morale was particularly low in this department as staff felt that the CT staffing levels were unsafe.
- Many staff in radiology wanted to speak with us about the staffing rotas in the department and the stress that staff were under. One staff member described the CT scanning room as a "conveyor belt" saying that they had no time to talk with patients. We were told that patients should have a 20 minute slot for CT scans, but were being booked in every ten minutes.

Outpatients and diagnostic imaging

- The ultrasound department opened from 8am to 8pm, Monday to Friday, with two evening lists running each day. On weekends the department ran up to three lists between 9am and 5pm.
- The ultrasound department was staffed with two managers, four sonographers, fifteen support workers, two agency staff and two students. The antenatal ultrasound rotated between two departments and was supported by two midwives and three support workers.
- Staff told us staffing rotas did not reflect the staff actually working in the department. We were shown examples of this during our inspection. Duty rotas had not been changed to reflect last minute staff absences, staff sickness had not been covered, and staff had been moved to work in other areas of radiology, but rotas had not been changed to reflect this.
- Breast screening was managed in a small, self-contained unit. Staff here felt supported and told us they were happy in their work. The unit was staffed by a radiologist and a technician.
- Haematology had insufficient staff for routine and out-of-hours services, which gave rise to loss or delays in provision of haematology/blood transfusion/ immunology services. Haematology had three vacancies, with one staff member on maternity leave. They planned to appoint agency staff to help out-of-hours services at Queen's Hospital and for the core service at King George Hospital. The plan, going forward, was to close some services in community settings in order to reallocate these staff into services at both Queen's Hospital and King George Hospital.
- Trust policy stated that medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The OPD audited compliance with this policy. Where the policy was not met, staff escalated this to divisional leads to be investigated.

Major incident awareness and training

- The trust had a major incident plan, which was available to staff on the intranet.
- The OPD areas would be used to treat minor injuries in the event of a major incident. Staff telephone numbers were kept in the department so that they could be contacted if they were required during a major incident.
- With the exception of OPD management, staff we spoke with were not aware of their role in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages.

Most staff had received an annual appraisal in line with the trust's policy. However, nursing staff did not receive clinical supervision.

We were shown examples of multidisciplinary working, with OPD running one-stop clinics in some specialties. The service ran clinics six days a week at the time of our inspection.

Medical secretaries in some specialties were unable to meet timeframes for sending general practitioner (GP) letters. This was mostly due to staff leaving the service and not being replaced.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established.
- Staff in the department demonstrated a working knowledge of NICE guidance for recognising and responding to acute illness in adults in hospital. The department used a multiple parameter scoring system to allow a graded response to patients who became unwell in the department. Staff had signed to say that they had read and understood relevant guidance.
- The tuberculosis (TB) clinic saw around 200 patients a month. The consultant told us this was the highest service provision for TB in the country. The clinics were run separately from other clinics to ensure that only patients with TB were in the patient waiting area. Some specialties, such as chest, sexual health and breast surgery, had one-stop clinics. The trust told us they were currently looking to expand the number of one-stop

clinics. Several bodies such as the Royal College of Pathologists and the Society and College of Radiographers recommend that the one-stop clinic system is preferable, as it provided a basis for definitive diagnosis, reassuring people with non-malignant conditions and informing the multidisciplinary team treatment planning. Research also suggests it is preferred by patients.

- Staff told us that the of the IT system could sometimes be slow, which made accessing policies and protocols difficult at times.
- The anticoagulant and deep vein thrombosis (DVT) service did not meet NICE guidance, as they were unable to review patients within 24 hours at weekends as the service ran from Monday to Friday. A children's outpatients department (COPD) audit had been completed by the trust, however, this focused on inpatient treatment only.
- Doctors in outpatients were able to show us that they were complying with best practice guidance. Radiotherapy's guidance was condensed national guidance and were easily accessible on their own database.
- Radiology staff were able to explain their safety protocols and the local rules were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part and these showed appropriate exposure levels.
- The laboratories had had full Clinical Pathology Accreditation (UK) Ltd (CPA).

Pain relief

- Patients we spoke with told us their pain was being managed well by staff in the department.

Patient outcomes

- Quality of care audits were performed in outpatients, which audited: information availability, cleanliness, staffing levels, medical records availability, equipment in working order, medicines management, and patient feedback. These were completed weekly and showed 100% compliance, but were currently only being collected at some clinics as the roll-out of these audits was being completed using one specialty at a time. Patient feedback was summarized, which was mostly positive.
- Cancer peer review scored at least 80% or higher on self-assessment. However, on peer review and validation in 2014, scores were lower; particularly multidisciplinary team (71%), acute oncology multidisciplinary team (17%), general acute oncology multidisciplinary team (45%), Cancer of the Unknown Primary (CUP) multidisciplinary team (38%). These were mainly due to a lack of a thoracic radiologist for the lung multidisciplinary team, a lack of administrative support for the prediagnostic multidisciplinary team, a lack of same-day CT scanning for a two-week wait, and lack of a data manager. There were also concerns regarding the lack of a lead cancer nurse, and changes to the lead clinician role.
- The Patient Reported Experience Measure (PREM) showed issues with waiting times and the workforce.
- Radiotherapy undertook both internal and external audits, which were mostly positive and put it in the top five radiotherapy units in the country. These included system audits, such as equipment calibration, image review processes and British Standards Institute (BSI) assessment as well as Royal College of Radiologists/ oncology audits, such as anal cancer toxicity and outcomes of radical chemoradiotherapy and breast radiotherapy technique.
- Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) audits were conducted in 2014, which showed 100% compliance. The last radiation protection review audit showed concerns regarding outdated procedures, but the procedures we reviewed showed no issues.
- Genito-urinary medicine (GUM) conducted audits, which included whether they were meeting 48-hour access for patients and uptake of HIV testing (which was 80% against a target of 85%).
- Local haematology audits took place, including contrast-induced nephropathy. This led to handheld devices being introduced and a study of patients pre-angiography.
- We requested patient outcome information for outpatients, such as physiotherapy audits, but we did not receive any.

Nutrition and hydration

- Although phlebotomy was located at the main entrance where there were food and drink shops and was near a water fountain, staff provided nothing additional, despite patients waiting constantly over two hours for their appointment. Also, the service was being operated on a ticket system, so it would be difficult for patients to move away from the area. No hot drinks were available in outpatient areas, although patients could get a drink from shops on site if they were given a pager. Food and drink was only given to waiting patients in exceptional circumstances when long waits occurred.

Competent staff

- We were shown competency assessments for staff working in the radiology department along with temporary staff to the department. These were completed during staff local induction to the service.
- Safety concerns were raised by a number of radiology staff about their competencies in CT Scanning. They told us that, due to staff shortages, they were not rotated into CT scanning to update their competencies. This meant that they felt that they hadn't had enough experience in CT scanning to keep up their competencies in this area. As a result, when they were asked to work overnight they could be called upon to complete a CT scan.
- When this happened they told us they would perform the scan, but that they would not feel competent to do so. This could result in irradiating patients unnecessarily with the scan, and not answering the clinical question due to the staff member not being competent to perform the scan.
- All new permanent staff undertook mandatory induction training. This included a corporate and local induction. Staff completed a checklist to ensure that all areas had been completed and this was recorded electronically.
- One hundred per cent of staff in the OPD department had received annual appraisals. This time was protected time and staff told us they valued this opportunity to discuss their learning and development along with any issues or concerns.
- Eighty-one per cent of radiology staff had received their annual appraisal in line with trust policy, this was above the trust target of 80%.
- Nursing staff were not receiving formal supervision. The nurse manager told us they had an open-door policy and staff could raise concerns with them at any time. We saw many staff asking questions of nurse management throughout our inspection.
- We spoke with reception staff, who demonstrated a clear understanding of their role. We witnessed patients being treated with courtesy and dignity by most reception staff, who signposted patients to other waiting areas when required. The role also involved coordination of patients going out of the department for other requirements, such as x-rays to ensure that they did not get lost.
- All staff identified as needing training on the patient administration system had attended training. This enabled them to process patient information more effectively and efficiently, giving them more time to spend with patients.
- The trust had developed an administration development programme, which had been well received by staff who had attended it. The four-day programme focused on several elements, including customer service skills and how to handle difficult situations. OPD management planned to send all staff on this programme.
- We spoke with a member of bank staff who had worked in the trust for four years prior to the inspection. They told us they felt undervalued, especially after the 'PRIDE' training. They said they had not received 'one-to-ones' with their manager and had had no appraisal except for a questionnaire sent to them by post.

Multidisciplinary working

- The OPD offered one-stop clinics in some specialties, such as the breast exam clinic. During the breast exam clinic, patients could receive an ultrasound, mammogram, and aspiration, dependant on clinical need. The clinic was staffed by a specialist nurse alongside a consultant. Specialist nurses offered a counselling service for patients.
- The OPD also ran one-stop clinics for diabetes, and endocrinology. These appointments were supported by specialist nurses. Most of the main OPD nurses had lost their competencies in venipuncture. We were told that this was because the matron did not think it was

necessary for staff to keep up to date with this competency. This meant that patients in these clinics needed to make separate arrangements with the phlebotomy services for blood tests.
- Staff were able to access dieticians and pharmacy support in clinics, where needed.

Seven-day services

- Clinics ran across six days at King George Hospital. Weekend clinics were used to assist with capacity where waiting lists demands were greater than clinic capacity.
- Between 8pm and 8am daily the CT scanner was available for emergency work. The radiographer was resident in the hospital to cover this service. General x-rays were available seven days per week.
- Radiographers covered the hospital on an on-call basis overnight.
- The ultrasound department opened 8am to 8pm, Monday to Friday, with two evening lists running each day. On weekends, the department ran up to three lists between 9am and 5pm.
- The call centre was opened between 8am to 6pm, Monday to Thursday, and 8am to 5pm on Fridays. On a Monday and Thursday, the call centre received, on average, 1,500 calls a day. On a Tuesday, Wednesday and Friday they received around 900 calls per day.

Access to information

- Health records were stored in a facility off site and bought to the hospital four times a day. Clinic preparation staff aimed to prepare clinic health records four days in advance of any clinics. However, on the day we were inspecting, notes were being prepared for clinics for the following day. We were told that, currently, this was typical of the amount of time before clinic that staff were preparing health records.
- In order to improve the service, the department now employed 'runners' who chased and collected clinic health records. Staff told us most clinics ran with health records missing for some patients. We were shown a typical clinic being prepared for the following day, where two out of nine health records were missing.
- We were told that, where health records were missing, the clinician was informed and would make a decision on whether they were going to continue with the patient's appointment using a temporary set of notes. Where clinicians were happy to do this clinic preparation staff would make a set of temporary notes for the patent. We were told that the amount of temporary sets of notes in circulation caused further problems for medical records as these notes needed to be incorporated in the main set of patient health records when they were found and this was not always happening.
- The trust had completed a 'snapshot' audit of temporary patient health records used in OPD clinics in the week of the 9 to 15 of February, 2015. Of 13,836 patient appointments during that week 1,157 patients had a temporary set of patient health records. This was a total of 8% of patients seen.
- All clinics and wards had access to the picture archiving and communication (PAC) system, which was password protected and provided access to results. GPs were sent paper reports, but could also access radiology reports through the pathology reporting system.
- The PAC system linked all the patient examinations and reports together, which meant that the radiologist could access all examinations and reports during the reporting process.
- On one morning of our inspection, there was an IT failure in the main OPD. This delayed clinics for around an hour, as clinicians were unable to access patient records, including diagnostic results and clinic letters. One consultant told us, "The IT system can be good when it works, but it is very slow. It takes around ten minutes to log in which impacts on my clinic time."
- Medical secretaries aimed to complete GP letters within five days of a patient's clinic appointment. These letters informed GPs about decisions made in clinics and any aftercare that was needed. We spoke with two sets of medical secretaries about compliance with the five-day turnaround.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Although the staff that we spoke with told us they had received training in the Mental Capacity Act 2005, we found that their knowledge was variable, with some staff not able to demonstrate a sound knowledge of the principles of the legislation.
- The training database held in the department showed that all staff had completed Mental Capacity Act 2005 e-learning training.
- We were told that, where patient mental capacity was questioned, clinicians would assess their capacity and

check for clinical issues, which could impact on a patient's memory. If appropriate, they would then refer the patient to the memory clinic for further investigation and support.

Are outpatient and diagnostic imaging services caring?

Requires improvement

We found that most staff were polite and courteous when communicating with patients. Although we did see areas for improvement with customer service for some staff members.

The cancer experience survey rated all but seven areas in the bottom 20% of trusts nationally.

Due to reception desks being in waiting areas we found that patients' personal details could be overheard when staff were booking them into clinics.

Compassionate care

- The cancer experience survey rated all but seven areas in the bottom 20% of trusts nationally. In response the hospital had conducted its own internal audits and they found that patient experience levels for cancer at the hospital were vastly more positive, with feedback consistently showing that 90% of patients would recommend the service.
- The NHS Friends and Family Test score for outpatients was 76, with 96% recommending the service. The test was being piloted and it was expected that trust would introduce the test for OPD by April 2015. The trust planned to have the test fully implemented throughout OPD by October 2015.
- The OPD operated a continuous patient experience survey which patients were encouraged to complete, following their visit to the department.
- NHS Friends and Family Test scoring had been adapted for use in OPD and had recently been introduced.
- Patient survey results and NHS Friends and Family Test scores had not been displayed in areas of OPD.
- An office door at the entrance to the OPD was blocked by a table. We asked the staff here why they had blocked the entrance to the office. They told us it was to prevent patients from entering the room to talk to them. We were told by staff that they found patients from other areas distracting when they asked for assistance.
- However, we observed most staff interactions with patients as being friendly and welcoming. We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there.
- We saw particularly good examples of caring interactions by healthcare assistants. For example, friendly greetings getting down to a patient level to interact with them and maintaining eye contact.
- One patient who attended the department regularly told us, "The staff here are nice, very caring." Another regular attendee said, "We often get delays of around an hour and a half, but the doctor always apologises. Today its running thirty minutes late and I think that's reasonable." We did, however, witness one receptionist managing five patient interactions without smiling or looking at the patient. They kept their face turned to their computer screen and their verbal responses to patients were dismissive and unfriendly. We raised this with an administration manager at the time of the inspection.
- One patient said, "The receptionist on base X could be friendlier, they could do with customer care training. They should be more patient focused and smiley."
- Reception staff told us when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. Staff told us they only used the last three digits of a patient's phone number and didn't use the house number when discussing their address. However, we were able to overhear patients private details discussed when we stood close to the desk. This showed that staff had not sufficiently considered ways to ensure that patient's personal information was protected.
- We saw that staff always knocked and waited for permission before entering clinic rooms. We also saw that clinic rooms had signage instructing people to knock and wait for an answer before entering, in order to maintain people's dignity.

Understanding and involvement of patients and those close to them

- Patients that we spoke with in phlebotomy were often confused as they had not been greeted by a member of

staff or provided with any information. They were expected to take a ticket from a dispenser with a number on it and wait until their number was called. However, there was no signage in the department to indicate to patients that this was what they should do. If patients asked at the reception desk at the back of the room they were told that they were a different department. If patients went into the phlebotomy treatment room to ask for information, staff there told us they were distracted by them, which was a safety issue.

- Elsewhere in OPD, patients we spoke with told us their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us they felt included in decisions that were made about their care and that their preferences were taken into account
- We saw literature being explained to patients in clinic. We saw patients being handed detailed information, which was explained to them by nurses who checked their understanding
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care. One patient told us, "The doctor is particularly good; they took time to understand my problem."
- The service provided chaperones, where required for patients. We were told that staff were always available for this.

Emotional support

- Macmillan nurses provided practical and emotional support in the cancer clinics and to patients on their pathways of care.
- The chaplaincy team told us that they made occasional visits to the outpatient areas and would always attend, if requested.

Are outpatient and diagnostic imaging services responsive?

Inadequate

The trust had stopped reporting referral-to-treatment times (RTTs) from September 2014 and was unable to evidence compliance with 18-week targets across all specialties.

The phlebotomy clinic was overstretched, with long waiting times and no capacity to prioritise fasting patients or children, as well as cramped seating areas that were unable to seat the number of patients waiting in the clinic.

There was a significant backlog in the reporting of x-rays. Chest x-rays were a particular issue, with 20% of films reported on for inpatients and 32% reported on for outpatients.

The patient journey through the department and waiting times for patients meant that some patients had received a poor experience in the service.

The hospital cancellation rate for 2013/2014 was 15% of appointments, with some patient's appointments being cancelled multiple times. This caused a poor patient experience along with extra work for staff.

An absence of water meant that patients could not access fluids without leaving the department. In some areas of the OPD, staff told us they would offer patients with long waits refreshments. However, the protocol on managing delayed clinics did not indicate how and when this should happen.

The height of reception desks throughout OPD did not meet with requirements for people using wheelchairs.

The hospital had a higher 'did not attend rate' than the England average. Service improvements in the call centre had improved patient experiences of this service. Calls were monitored to ensure continued compliance with call-answering statistics.

We found a lack of equipment to assist with the comfort and safety of bariatric patients.

Service planning and delivery to meet the needs of local people

- The trust had 'pay on foot' car parks for visitor use. Parking was charged based on the amount of time people were parked for. We saw that, where clinics overran, staff could assist patients with partial refunds on their parking costs. However, none of the patients that we spoke with who had complained about late running clinics were aware that they could discuss their parking costs with staff.
- There were no water coolers available in most areas of the OPD (with the exception of the physiotherapy/ rheumatology area). Patients waiting for long periods of time in cramped conditions in the phlebotomy clinic

were unable to access fluids without leaving the department. Patients told us they were reluctant to do this, as they would lose their place in the queue. We were told by staff that there had previously been a water dispenser in this area, but that it had been removed as children would play with the water, making the floor wet and causing a slip hazard. There were plans in place to reinstall water coolers during the redesign of the department.

- We were told by staff that patients attending for other OPD appointments could be offered drinks when clinics were delayed. The protocol for clinic delays did not indicate that this was the case, or how long a clinic needed to be delayed before patients were offered refreshments.
- Patients and other visitors had access to a coffee shop and restaurant area in the main hospital entrance lobby. However, patients told us they didn't use this, as they were afraid of missing their appointment. The trust had trialled pagers at their other hospital and we were told that they would soon be introduced to King George Hospital outpatients site.
- The phlebotomy service at the trust covered a local population of around 750,000 patients. Blood was drawn by staff at seven in-house locations, 30 wards and 15 outreach locations. During the year 2013/14, the Barking, Havering and Redbridge University Hospitals NHS Trust phlebotomy staff drew blood from 524,671 patients. This was a 12% increase over the two years prior to our inspection. The local area also has a high incidence of lung cancer, due to the high level of smokers in the local population. In 2014, the consultant told us they saw around 20 to 25 patients a week, but that this figure had risen in 2015 to around 40 per week. As a result the trust had proactively undertaken smoking cessation classes in conjunction with local general practitioners (GPs).

Access and flow

- The referral-to-treatment time (RTT) rate was better than average up to November 2013, but no data was available from this date, as the service had stopped reporting. The hospital was due to start reporting again in January 2015, but this had not occurred and was likely to be delayed until at least April 2015. This was due to an issue with transferring from their old patient information system to their new computer system where processes had been set up the same without reviewing whether they would work on the new system.
- When the new computer system started, it showed around 110,000 patients that required an appointment: 100,000 non-admitted, 10,000 admitted, with 50,000 over 52 weeks. A validation project was implemented to find out how many patients actually required an appointment as some were flagging due to system, or recording issues. Estimates were that around 8,000 of the non-admitted patients required an appointment although this had not been fully validated. As of January 2015, 53,236 non-admitted patient pathways required validating, of which 18,057 were over 18 weeks and 893 were over 52 weeks, as the trust had focused on reducing the admitted pathway backlog first.
- To reduce the backlog, 3,000 appointments had been outsourced to other hospitals. To prevent this in the future, a new upgrade of the system was due to remove the errors and training was being given to reception staff to ensure clinical outcomes were recorded.
- Four specialties were getting more referrals than they were treating. Particular capacity concerns were in pain, diabetes, dermatology, neurology, orthopaedics and gastroenterology, where there was a recognised lack of consultants. However, these had not been evidenced in most areas, due to clinic profiles requiring updating. Anti-coagulation had a four to six week waiting list. We received information that referrals for eye casualty were being transferred to another trust.
- Audiology had waits of up to ten weeks for hearing aids. Some patients told us they had nearly a year wait for their appointment. The plan was to have all over 18 weeks completed by June 2015, by putting on an extra 200 clinics a month and by booking additional staff and coordinators. These staff were expected post-April 2015, on fixed term contracts to deal with the additional bookings that would be required post validation.
- Staff were measuring patients seen within nine weeks from referral for their first appointment until they could report on RTT. The last performance reported showed that 72% of patients were seen within nine weeks for their first appointment, which was consistent for the last few months. However, there were concerns regarding

follow-up appointments, with clinicians telling us these seemed to be very delayed and figures showing that waits for follow ups were much worse than first-time appointments.

- The trust attempted to manage this by calling each patient to establish whether they had been seen in clinic and what the outcome of this appointment had been.
- Two-week waits for cancer had recently become in line with the national average after a long period of being worse than the national average at 95%. Thirty-one day waits for cancer were consistently worse than the national average, though this was improving to 87%. Sixty-two day waits for cancer had been worse than the national average, but were recently just better than the national average at just under 85%. Histopathology were 100% compliant with seeing cancer patients in seven and twenty day waits, but were at 80% for ten-day waits where there was a large section.
- Pathways for patients with a suspected cancer were monitored in radiology by a cancer pathway manager who liaised with other departments to monitor compliance with the pathway waiting times.
- The call centre had made changes to their service and had improved the call answering times. They had done this by analysing the calls coming into the service and ensuring that staffing numbers were increased at peak times of the day. The call centre monitored the time it took to answer and complete calls, along with the number of abandoned calls. In February 2015, they had answered 97% of calls with 3% of calls being abandoned by the caller. This was above the service target of 90% of calls answered.
- Most patients went to one of the trust's hospital settings to have their bloods taken. Patients preferred to arrive early in the morning for their tests – either because they were fasting before their test, or they needed to go to work. The mornings were also busy at the hospitals because wards needed phlebotomy to be done early to expedite discharge decisions.
- Patients were reporting, and we observed, two to three hour waits for blood tests on every morning of our inspection – many of these patients had been fasting. We spoke with many unhappy patients, some of whom had brought children to the department.
- Phlebotomists were trained band 2 staff who were rostered to either take blood in the wards, in an outpatient setting or at an outreach location.
- We received many complaints from patients throughout our inspection regarding the responsiveness of the phlebotomy clinic. The phlebotomy clinic was located in the main OPD area. We noted that, on the four mornings we were inspecting, that the clinic was overcrowded with patients unable to get seats and blocking corridors that accessed the department.
- One patient who we spoke with at 9.40am said, "I arrived here at 7.45am, as I had to wait for my carers to help me get ready. I should have come a month ago, but I couldn't face it. It's bad here all the time; I am fasting and last ate at 7pm last night. I just want a cup of tea and a slice of toast." Another parent of a four year old waiting for a blood test told us, "We arrived at 7am and it's now 9.17am, the wait has been too long. We thought it would be quick. He is supposed to be at school." Another patient said, "This place is mobbed, I gave up my seat to a man with a walking stick."
- We spoke with phlebotomists, who asked to speak with us as they had concerns regarding the service. They felt that there should be a separate service for patients who were fasting. There was a poster on the entrance to the department explaining to patients that the service did not prioritise patients who were fasting. They also told us the service was overburdened and staffing levels did not meet with the demands of the service. They told us when they arrived in the department at 7am there would already be at least 70 patients waiting in the queue to be seen.
- We spoke with a manager from this service who told us that the week of our inspection had seen unprecedented numbers of patients through the service (all other staff that we spoke with told us what we were seeing was a typical picture of the service). The manager also told us seven phlebotomists were off sick across the trust at the time of our inspection. They said, "We all know that there are not enough staff in the mix."
- In order to improve the patient experience through the phlebotomy service a capacity and demand study had been completed. Forecast calculations in the study showed that the demand on the phlebotomy service was increasing at an average rate of 5% per year.
- Recently, there had been a trend of local phlebotomy locations closing and the trust was expected to meet the additional demand. Broad Street had closed earlier

in 2014, resulting in an additional 20 to30 patients per day and Gants Hill Medical Centre (Redbridge) closed their phlebotomy service on 1 August 2014, resulting in an additional 10 to 20 patients per day.

- With demand increasing, space already an issue at certain times of the day, and staffing levels already stretched, the study showed that forecast predictions in phlebotomy with long patient waits and multiple complaints was set to get worse, unless steps were taken to address the issues.
- A 'Quality and Safety Exception Report' for Radiology had been submitted in April 2014. The report outlined the departments ongoing risk of unreported plain film images (A&E chest x-rays being most noteworthy) and ongoing suboptimal appraisal and training rates. The report noted a backlog of CT scans and reporting the estimate for clearing the backlog at this time was eight to 10 months, as there were resource/capacity issues.
- The radiology dashboard showed that, across the trust in January 2014, MRI scans took an average of 26 days from referral to scan date and a further day for reporting. Ultrasound scans took 29 days from referral to scan. The department had an issue with a backlog of reported x-rays. From April 2014 to the present the department had an average of 40% of reported films for inpatients and 73% reported films for OPD. The worst results were for chest x-rays, with 20% of films reported on for inpatients and 32% reported on for outpatients.
- Referrals for new appointments came into the service through 'choose and book', via post, fax, email, or from consultant to consultant. Once received, paper referrals were scanned onto the shared drive where they were attached to the relevant patient file. Consultants then triaged the referrals within 48 hours, at which point the booking centre was responsible for making the appointments.
- Where inappropriate or incorrect referrals had been made consultants would flag this up during triage and the referral would be sent back to the GP for attention. We were told that the service had difficulty with some consultants not triaging their referrals. We were told that, where this happened, the OPD improvement group would engage with clinical leads.
- If patients could not be booked into a clinic within the expected timeframe this would be escalated to consultants and service managers who would make a decision on how that would be managed on an individual basis.
- Once a patient had been seen in a clinic, an outcome form was completed. This form showed what decisions had been made in clinic and whether the patient needed a further appointment, a referral to another service or whether they had completed their course of treatment. This information informed the trust about compliance with the two-week and eighteen-week referral-to-treatment times. Any incomplete outcome forms would be investigated by the service manager, who would track the outcomes and input the data into the electronic reporting system.
- In order to meet with the demand for capacity, the OPD was running extra clinics, including weekend and evening clinics. In February, the OPD had run three extra day-time clinics, 18 extra evening clinics and eight weekend clinics.
- Booking staff told us that one of their frustrations was the amount of times patient clinic appointments were cancelled by the trust and rearranged. Between July 2014 and January 2015, the trust cancelled and rearranged 5,048 patient appointments. Once, 205 patients had had their appointments cancelled and rearranged twice and 16 patients had had their appointment rearranged by the trust three times.
- The hospital cancellation rate for 2013/2014 was 15% of appointments. The patient cancellation rate was 7% of appointments. Twenty-four per cent of appointments were first appointments and 43% were follow-up appointments for this period.
- The average time during this period for patients attending a first appointment following a cancelled appointment was 11 days. However, the average time for patients attending for follow-up appointments was 53 days. This caused a poor patient experience along with extra work for staff.
- Patient waiting times in clinics had started to be monitored by the trust. However, this was not done consistently across all clinics, so they were unable to provide a full picture of waiting times. The phlebotomy clinics where we saw poor patient experience regarding wait times for appointments had not audited waiting times in clinic. We were told by both staff and patients that the availability of patient health records caused issues in OPD clinics. We spent time with the clinic preparation staff, who described the processes in place to request and prepare patient health records for clinics.
- During 2013/14 did not attend rates for the hospital averaged at 10%. This was higher than the national

average of 8%. In order to improve did not attend rates, the trust had made service improvements. Late notice appointments (within seven days) were only made when staff had been able to speak with the patient on the telephone and they had agreed the appointment. Systems had also been streamlined so that there was one single contact number for all our patients to access the call centre. Previously, there had been three different numbers in use.

- Forty per cent of patients received text message reminders. The department was about to change the message that went out to patients to try to improve did not attend rates.
- The service had created a poster, which they were distributing via Healthwatch, which explained to patients in a variety of languages the importance of attending hospital appointments. The department was also looking at ways to reach the groups of patients with the highest non-attendance rates: the under 18s and the 25 to 35 age group. Partial booking was being introduced to improve non-attendance rates.
- Work was being done with the profiling of the clinic. This piece of work was around ensuring that the capacity in clinic profile met with the demands on the service. The trust had completed 64% of the clinic profiles at the time of our inspection. New clinic profiles did not have the facility for staff to overbook clinics. It was felt that, because templates would meet the capacity demands, overbooking of clinics would not be needed.
- Haematology consultants had trialled the use of an electronic clinic outcome form while in clinic. This meant that, before a patient left clinic, their pathway had been updated and their next appointment agreed. This gave consultants control over their clinics, while improving the trust's internal processes. The trial had been a success and had been extended to neurosurgery. Feedback has been so positive that several other specialist consultants had requested to trial it.
- To ensure patients were seen in the right clinic by the right consultant, the trust had been trialling a new system of electronic referral triaging in the ophthalmology department for a 'choose and book' referral. Previously, administrative staff had been reliant on using paper-based systems, which caused delays and inefficiencies, and the risk of a patient being booked into the wrong clinic was more likely.
- During our inspection, we witnessed a quick response by the department to deal with an unexpected incident. Unfortunately, the clinic consultant had been involved in a car accident on the way into work. The consultant had managed to still get to the clinic, but was delayed. The department were instructed not to cancel the clinic at short notice. A clinician in clinic saw the follow-up appointments leaving the new patients to be seen by the delayed consultant. Patients were kept informed at all times and the staff in clinic managed the situation calmly and efficiently.
- We were told that patients should have a 20-minute slot for CT scans, but were being booked in every ten minutes.
- Rheumatology secretaries told us they were currently behind on this deadline as a member of staff had left and not been replaced. The gastroenteritis secretaries also told us they were not meeting the deadline. They said they were currently working two to three weeks behind. This was also due to staff leaving and not being replaced. At the time of our inspection, the secretaries in the gastroenteritis clinic had 203 letters for typing on the shared drive with 109 of these being over the five-day turnaround.

Meeting people's individual needs

- There were no bariatric treatment couches, or bariatric chairs in any of the waiting areas. Although the couches in the treatment room had a suitable weight specification, the trolley specifications were too narrow for a bariatric patient.
- The phlebotomy treatment room was crowded and did not have space for patients with mobility aids, and parents with pushchairs to manoeuvre safely.
- The height of reception desks across OPD were not accessible for patients using wheelchairs. We were told that this had been considered and that when the department was renovated and the reception desks would be made with lower heights to accommodate people with disabilities.
- The OPD was able to access telephone translation services for patients. This could be arranged without notice when patients who required the service presented themselves in clinic. We saw examples of this happening during our inspection.
- The OPD had a link nurse with a special interest in learning disabilities. The OPD had folders for staff that included information for assisting patients with a learning disability. The information included a variety of communication tools, along with information and spare

copies of the Hospital Passport. Hospital Passports were completed at home and bought into hospital to give staff information on the best ways to care for each patient's individual needs.

- The nurse working in the breast screening clinic had been highly commended by a breast cancer support charity for the work that they had put into improving their service to assist patients with learning disabilities in preparing, and being supported through, the clinic. They had changed the way that care was delivered by ensuring that patients with learning disabilities were booked at the start of clinics and given a double appointment slot to give them time to understand all the information given. The team also offered patients a tour of the department to help to reduce their fears of an alien environment.
- Staff ensured that patients who may be distressed or confused by the OPD environment were treated appropriately. Patients with a learning disability, or diagnosis of dementia were moved to the front of the clinic list. The OPD staff liaised, where needed, with ambulance transport staff to ensure that this process ran smoothly.
- The OPD had a link nurse for dementia who ensured that they were informed of new initiatives and best practice and shared this with the rest of the team. OPD used the Butterfly Scheme adopted in the rest of the trust, which highlighted patients with dementia.
- Staff told us that, where ladies required a female doctor to examine them due to cultural or religious preference, this request would always be respected.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy-to-read formats.
- A GP liaison manager had just been appointed by the hospital. Their job was to work with community and primary care providers, acting as a single point of contact for enquiries and issues, and helping to improve communications between GPs and the trust.

Learning from complaints and concerns

- The trust had a 25-day protocol for the completion of formal complaints. Complaints were reviewed at divisional level and any learning from the complaints was fed back to the staff in the department. Action plans were instigated, following a complaint and staff were given responsibility for ensuring that any actions were completed within the given timeframe.
- We were shown a copy of a complaint and the action plan that was drawn up as a result. We saw that actions had been completed within the given timescale.
- Managers were able to talk us through examples of where practice had changed within the service following a complaint.
- Most patients we spoke with told us that they would feel comfortable making a complaint and would know how to go about this. One patient said, "I would feel confident in reporting any complaints." Another patient said, "I have made a complaint. I went to reception to complain about delays, I got my parking paid for, which I was happy with."

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was a sense that different areas of the OPD worked in isolation and we saw examples of where staff did not take responsibility and were reluctant to assist patients who were attending other areas of OPD.

Some staff groups felt under a great deal of workplace pressure, and reported that they felt unsupported by their managers.

All of the staff we spoke with were aware of the trust's vision and values and were able to describe the 'PRIDE' initiative to us.

OPD had defined what they felt 'good' looked like for their service. Staff were able to confidently discuss where they were achieving 'good' results, as well as the areas that needed to be improved.

Some department risks were not included on the departments risk register. They were, however, being managed outside of the risk register in the improvement plan risks and issues log.

The OPD was taking part in quality assurance audits, but some of these were snapshot audits that did not show a complete picture of the issues.

Staff had been involved in some aspects of the service improvement plans and nursing staff reported being encouraged to find innovative ways to improve the service.

Outpatients and diagnostic imaging

Vision and strategy for this service

- All of the staff we spoke with were aware of the trust's vision and values and were able to describe the 'PRIDE' initiative with us.
- OPD had defined what they felt 'good' looked like for their service. They felt that good for their service would mean: right patient, right clinic, right time, right doctor, and all the right information. Staff were able to confidently discuss where they were achieving 'good', as well as the areas that needed to be improved.
- OPD vision and developments were a standing agenda item at team meetings. This meant that staff were able to show how the service was learning from governance, patient feedback, incidents, and complaints and were able to demonstrate service improvements that these areas generated.
- Strategies for service improvements were in place. Progress against targets was monitored to ensure that service improvements were made in a timely manner. Staff were able to confidently discuss their progress on service improvements along with areas that had been identified as still requiring improvement.

Governance, risk management and quality measurement

- The OPD completed weekly quality of care audits. These audits looked at the environment along with patient experiences. Five patients were interviewed for each audit where they discussed their experiences through the service.
- The matron attended monthly directorate clinical governance and risk meetings.
- The risk register for outpatients included one risk from 2008 referring to the standard operating procedure for clinic cancellations, which had been ignored, with clinics cancelled with less than six weeks notice, and a lack of prioritisation in rebooking. This risk was last reviewed in December 2013, after the procedure was revised, which had resulted in reduced cancellations.
- Another risk from 2008 was regarding health records not being tracked correctly. Non-compliance was audited, with action plans and training in place, but these tools had not been utilised by staff. This was last reviewed in December 2013. We were told that this was still an issue during our inspection, with snapshot audits confirming this. However, we were unable to evidence this with robust data as the number of missing health records at clinics was not audited consistently across all clinics.
- A risk from 2008 included lack of staff to merge temporary and permanent patient files. During our inspection, we were told that work on this had been done, but that it was still an outstanding issue. This risk was last reviewed on the risk register in December 2013.
- There were no risks on the risk register regarding RTT, did not attend instances, hospital cancellations, radiology incidents, or waiting times. Despite widespread acknowledgement amongst staff and managers that these posed an issue for the department. However, the department had an improvement plan, as well as a risks and issues log. This included achieving the right workstream membership, staffing capacity, current updating of the IT system, breaching 18-week RTTs, communications with recruitment, actions from executive walk rounds, quality of electronic patient information records, staff buy-in to improvements and the review of the directory of services.
- Mitigations were in place, including additional recruitment, networking with GPs, training in RTT processes and communication between different staff members.
- Performance metrics, including those from the improvement plan below, included the number of patient hospital changes, did not attend rates for follow up and first appointments, first appointments seen within nine weeks, percentage of patients seen by another clinician, 'choose and book' referrals reviewed within 72 hours, time from cancellation to new and follow-up appointments, percentage of patients receiving letters, urgent cases scheduled in three weeks, and refresher training on the electronic patient information system. Actions taken included policies and procedures for case note tracking, and creating an outpatient user group meeting.
- There was a trust-wide improvement plan that also monitored OPD. Progress in December 2014 included workstream workshops, call centre answer rates improvement, IT training, pilot outcome form and electronic triage for ophthalmology. Key performance indicators (KPIs) were call centre answer rates, referral to another clinician, did not attend rates for new appointments, patients seen in under nine weeks, and patients with hospital-made changes to their

appointments. A bulletin on this highlighted the progress, plus a clinic cleaning programme, electronic referral triage for ophthalmology 'choose and book', clinic outcome forms for haematology and oncology, and the standardisation of clinics. Next steps included a review of issuing OPD letters, a single contact number for the call centre, standardised OPD uniforms, continuing the cleaning of clinics, reviewing did not attend rates, finishing the directory of services, and continued refurbishment of the department.

- There was a 'deep dive' presentation into outpatients in an improvement plan oversight meeting. Solutions to concerns started by listening to patients and staff via various methods. Issues raised by patients included car parking, décor, cancelled clinics, contacting the call centre, missing notes, queues, not receiving letters and incorrect information.
- Board minutes from February 2015 discussed the risks with RTTs. It stated that the trust was still validating non-admitted pathways, but had plans to clear the backlog by sending patients to independent hospitals.
- The patient experience lead had devised an audit sheet that recorded clinic start times, reasons for delayed clinics, the appropriateness of clinic slot times, and missing health records in clinics. This audit was performed in a different clinic each month, so although it gave a snapshot picture of compliance with these issues it did not give a full picture across all clinics each day.
- A review of the radiographer clinical alert system had taken place in December 2014. National health service breast screening programme guidelines stated that a system should be in place to alert the reader to significant clinical signs or symptoms noted by the radiographer, or reported by the women at the time of screening. The aim of the audit was to review the effectiveness of the current radiographer clinical alert system for signs and symptoms and determine if a change in protocol could reduce clinical recall to assessment for insignificant findings.
- The audit resulted in a change of practice with the trust amending the way that alerts were managed, the service strictly following all criteria's regarding holistic needs forms and prescription information in particular. The audit also identified the need for intensive administrative support following which, additional staff were employed by the service.
- The integrated governance group met in January 2015 and stated that their main corporate issues were around diagnostics, with patients being transferred to other centres for treatment.
- The pathology directorate had recently added Provision of OPD Ambulatory Antibiotics Therapy – ambulatory care to their risk register. The service had been running since June 2010. At that time, it was provided by two consultant microbiologists in addition to their existing workload. No dedicated funding or sessions accompanied the creation of the service. Since February 2014, one consultant had withdrawn from offering the service and hence it has been provided by only a single consultant. The workload has shown a constant increasing trend and could no longer be provided within these resources.
- The ophthalmology service held a clinical governance meeting monthly. During this meeting, they discussed incidents, NICE guidance and clinical effectiveness.
- The Clinical Pathology Accreditation (UK) Ltd (CPA) had completed a surveillance report on the haematology and immunology department at the trust, which covered both the Queen's Hospital and the King George Hospital site. The visit assessed the quality management system. The report identified 30 mandatory breeches and one recommendation. Following the surveillance visit, the trust had devised an action plan to address the issues found. Actions on the plan were due for completion by May 2014.

Leadership of service

- The matron oversaw the main OPD, but had no clinical leadership responsibility for other OPD areas, such as respiratory, chest, physiotherapy rheumatology and phlebotomy. Although these clinics all took place within the OPD environment. This manifested itself with the lack of interest staff showed in the phlebotomy clinic which they all went through every time they walked between the entrance of the department where the sister's office was situated and the main OPD areas.
- Phlebotomy staff told us they were under a great deal of pressure and felt unsupported by their managers. They showed us the transcript of their concerns, which they told us they had read out at a staff meeting two weeks prior to our inspection, but had not yet received a response to. Part of the document stated, "Despite the importance and value of what we do, we are continually treated as underdogs, undervalued and disrespected.

Not least by our own managers who choose to totally ignore us on the rarest of occasions that they set foot into our department. Between us, we have a wealth of skill and knowledge opinions and ideas which go by unnoticed and unheard." It was noted that sickness levels in phlebotomy were the highest within the trust, at 13%.

- In a staff focus group of 13 staff from the radiology department, three staff were able to tell us who they were managed by and who they went to when they had concerns.
- Radiology staff expressed high levels of staff stress within their department. They felt that they experienced low levels of support by their managers. They gave us numerous examples of how they had felt that their concerns had been ignored by managers. One consultant told us they had found that the management structure had changed too quickly and that they had not engaged with consultants at the hospital, they said this made them feel impotent when it came to affecting change. However, another consultant told us the new executive team were, "A breath of fresh air, they are proactive and I feel listened to."
- Staff survey results showed that the percentage of staff suffering work-related stress in the trust was higher than the national average, with 44% of staff reporting that they had suffered with stress as a result of their working environment.
- Most of the staff that we spoke with were complimentary about changes that had occurred in the executive team. There was a sense that staff felt that the trust was heading in the right direction, with strong and clear leadership at the top.

Culture within the service

- Radiology staff told us the workload was relentless and that they went without breaks. One member of staff who had a medical condition that relied on them eating regularly told us they worked from 1pm until 8pm with no break. They told us no one had completed a risk assessment on them regarding their health issues. When they raised this with a manager they were told, "You chose to work in CT." One member of radiology staff said, "It feels like you are being used and that nobody cares about you, or the balance of your life."
- Some administration and reception staff told us they felt "undervalued" and "not supported". They described to us occasions where they had suffered verbal abuse by patients who were frustrated at the wait times in the phlebotomy clinic. They said that, following verbal abuse by patients, they had filled in incident forms, but had received no support, no feedback, and that nothing had changed.
- We noted staff evaded responsibility by passing it on to someone else in the OPD department. Staff avoided assisting patients who were not from their area of the OPD. Where we found issues with resuscitation trollies, staff were all quick to tell us this was someone else's responsibility.
- Staff we spoke with were candid throughout our inspection about both the good parts of their service and the areas that required improvement.

Public and staff engagement

- The patient experience lead for OPD completed a regular quality of care survey, where five randomly-selected patients were interviewed about the quality of care they had received. They reported their findings from these surveys to the OPD management team.
- The outpatients improvement group met fortnightly. The objectives of the group were to deliver the actions to implement the outpatients improvement plan, to engage and improve communication with patients and staff in the OPD, to review OPD demand and capacity to reduce the number of clinic cancellations and delays, to review OPD service requirements, to review OPD administrative staffing requirements, to maximise technology innovation, and to improve patient environment and experience.
- The trust had run a workshop to review and refresh the outpatients work stream plan, to make sure that they had the right actions in place to continue to make the necessary, sustainable improvements for patients. This included feedback from patients and residents at a recent listening event, which had been hosted jointly with the local Healthwatch.
- Outpatients staff had chosen new uniforms and had decided on the colours used in the trust's 'PRIDE' wheel for these.

Innovation, improvement and sustainability

- Nursing staff we spoke with told us they were encouraged to consider feedback and innovative ideas. They said they would feel confident doing this and would feel that their ideas were listened to.

Outpatients and diagnostic imaging

- The OPD matron had attended a seminar at a neighbouring trust where they reviewed their outpatients improvement plan and shared learning from that trust's experience of implementing improvements.
- We were given examples of where nursing staff had approached managers with ideas for improving the service. One of these ideas improved the use of treatments and storage facilities.
- We received the outpatients improvement plan, dated 25 September 2014, which was reviewed every two weeks. It was still a 'red risk', mainly due to the booking of patient slots, and the management of the referral process. Clinics were due to be profiled by September 2014, but this target had been missed. Directory of services was due to be reviewed by the same date, but had also been missed. Clinics were due to be left vacant for appointment bookings by August 2014 using firebreak clinics, but only a few consultants had started using these. The NHS Friends and Family Test survey was due to be implemented by September 2014 and to get a score of at least 50%, but piloting was still small. Time to answer calls was due to be less than a minute, though no target date was set, but this had not been achieved. Call abandonment rate was due to be less than 10%, but no target date was set, although this had been achieved. Patients were due to be seen within 15 minutes of arrival, but no target date had been set and current audits could not clarify if this target was being met. No medical records should have been missing, but no target date was set and this had not been met.
- Pagers were being trialled at the Queen's Hospital site, for patients to take with them if there was over a 30-minute delay, or if a patient was visually or hearing impaired so they could leave the waiting area if they so wished. These were due to be rolled out across the King George Hospital site.

Outstanding practice and areas for improvement

Outstanding practice

? Medical care - Patients referred for cardiology appointments were seen within seven days, which was better than most trusts in the country ?

- The critical care outreach team provided a 'critical care follow up outpatient's clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their admission.
- The critical care outreach team had devised a tracheostomy discharge checklist for patient's leaving the hospital with a tracheostomy. The checklist supported teaching key competencies to patients, family and carers in how to support a person with a permanent tracheostomy.
- We observed the critical care team supporting patients and their families with their individual needs in a flexible, thoughtful, patient, considerate and caring manner; this support and care extended through to their colleagues.

Areas for improvement

Action the hospital MUST take to improve

- Display the numbers of staff planned and actually on duty at ward entrances in line with Department of Health guidance.
- Ensure when patients have multiple drug charts, that their assessment for venous thromboembolism (VTE) are recorded on all charts.
- Ensure that medical staff complete prescription spaces on drug charts before they start new charts.
- Improve the medical staffing cover at night and on the clinical assessment unit.
- Ensure that all incidents including patient falls are accurately reported electronically
- Ensure that patients who sustain a fall receive a medical review in a timely manner.
- Ensure that clinical guidelines are up to date.
- Review whether staff wearing hats is consistent with best practice guidance on infection prevention and control
- Ensure that speech and language therapists are trained and competent to care for patients who have tracheostomies.
- Ensure that sufficient nurses can perform swallow assessments on patients, so that patients are not left nil by mouth for longer than they should be.
- Ensure that medical outlying patients have an identified medical team to review their care and an agreed escalation plan in place
- Comply with the duty of candour legislation
- Ensure that medical and governance leads have appropriate input in to investigations of serious incidents
- Ensure that entries made by medical staff in patient records comply with the expected professional standards
- Prioritise the expansion of the critical care services across the trust to meet the needs of the population it supports to improve service planning and capacity.
- Improve shared learning opportunities in relation to incident, complaints, concerns and innovative ideas between all clinical staff within critical care across the trust.
- Include a dietician as part of the critical care multidisciplinary team as per the core standards for intensive care guidance.
- The Emergency Department must ensure that it routinely records, assesses and learns from incidents that occur.
- The Emergency Department must undertake a full review of the appropriate nursing staffing establishment for the department.
- The Emergency Department must continue its effort to increase the number medical staff, particularly at consultant level.
- The Emergency Department must ensure the robust supervision and learning of medical staff. Ensuring all staff have regular meetings with a named supervisor, and staff are given time for leaning and development.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

DC to review - some are potentially Musts

- Review the number of medical staff cover for the medical wards at night.
- Review the staffing levels on Ash Ward.
- Ensure that junior medical staff are aware of the trust's complaints procedure
- Ensure that nurses understand the importance of the recommendations stated by the speech and language therapy team
- Review the impact on patient confidentiality of patient information boards placed in corridors
- Ensure the fracture neck of femur pathway is always fully completed as required
- Ensure post take ward rounds for orthopaedic patients always take place
- Ensure that the resuscitation trolley on the discharge lounge is accurately checked daily
- Consider ways to increase multidisciplinary team working within critical care.
- Consider ways to engage patients in providing feedback specifically related to critical care services. This would capture the patient experience and provide a rich source of information as to how well the service performs and whether anything could be improved.
- The Emergency Department should review its response to major incidents including, equipment, staff training and practical testing.
- The Emergency Department should review its poor performance in FFT scores and develop a plan for improvement.
- The Emergency Department should improve the physical environment of the relatives room.
- The Emergency Department should review its performance against national targets such as the 4 hour treatment time and the potential for alternative patient pathways.
- The Emergency Department should ensure that all staff are fully consulted upon, and aware of future plans for the department.