

Barking, Havering and Redbridge University Hospitals NHS Trust

Inspection report

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Ratings

Overall trust quality rating

Requires Improvement 

Are services safe?

Requires Improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires Improvement 

Are services well-led?

Requires Improvement 

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of approximately 800,000 in outer North East London and Essex. The trust operates from two sites; Queen's Hospital and King George Hospital, with approximately 900 beds across both sites. The trust employs over 8000 permanent staff, sees over 300,000 attendees through their emergency departments and delivers over 7000 babies a year.

This inspection was part of a follow up on our previous system wide review of urgent and emergency care services across the North East London (NEL) integrated care system that was carried out in November 2021. At that time, we identified issues with flow in and through the urgent and emergency (UEC) pathway and had significant concerns regarding the impact of this on safety and quality of care. Due to ongoing concerns regarding the UEC pathway and patient safety, during November 2022 we inspected all four urgent treatment centres (UTC) provided by the Partnership of East London Cooperatives (PELC), and both emergency departments (ED) and medical care provided by Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT).

Subsequent to significant concerns that were identified at these locations, the Commission found that the challenges these services faced were also complicated by wider challenges within the health and social care system. A Quality Summit with NHS England and system wide partners was convened to devise an action plan to address the concerns identified.

Overall summary

- The trust faced continued challenges with access and flow into and out of the emergency department. Patients who accessed the emergency pathway did not always receive timely treatment when needed and were not always cared for in the best place for their treatment needs. Patients in the emergency department could not be moved promptly to specialist wards or mental health facilities due to lack of capacity.

Our findings

- The trust had declared a serious incident in August 2022 relating to the accuracy of their patient tracking list (PTL), where it was found that patients who should have been on the PTL awaiting an appointment for diagnostic imaging had not been. It was not clear at the time of inspection what the outcome of any clinical harm review was, either in relation to the extent of the harm or the number of people impacted.
- The trust had committed to fostering an open culture where patients, their families and staff could raise concerns without fear. However, some staff did not always feel respected, supported and valued.
- Senior leaders and teams used systems to manage performance. However, they did not always identify and escalate relevant risks and issues, and initiate actions to reduce their impact, in a timely way. The effectiveness of divisional risk management and oversight was variable.
- The trust was improving the way staff could find the data they needed in more easily accessible formats, to understand performance, make decisions and improvements. However, the current information systems were not well integrated, and the use of paper records meant that patient's records were not completely secure.

However:

- Services had enough nursing staff to care for patients, although there were some gaps in medical staffing provision.
- Senior leaders had the skills and abilities to perform their roles. They understood and managed the priorities and issues the trust faced. They were visible and approachable to staff and patients.
- The trust had a vision for what it wanted to achieve and was developing a strategy to turn it into action, through engaging with relevant stakeholders.
- The trust promoted equality and diversity in daily work and were developing opportunities and strategies for staff career development.
- Senior leaders were reviewing and redesigning governance processes throughout the trust and with partner organisations. The effectiveness in monitoring quality and risk was being assessed and the trust was working to identify how to improve processes.
- The trust planned care to meet the needs of local people and engaged well with other healthcare providers and system partners to plan and manage care.
- There was improved engagement from senior staff in understanding the financial challenges the trust faced.
- Staff treated patients with compassion and kindness. We found examples of staff delivering good care in a difficult working environment. However, ensuring privacy and dignity within the busy environment of the emergency department was not always possible.
- Senior leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Queen's Hospital urgent and emergency services

Action the trust **MUST** take to improve:

- The trust must ensure that personal privacy and dignity of patients is maintained for patients, including those located in the corridors outside the ED. [Regulation 10: Dignity and respect]
- The trust must improve oversight of time to triage of patients arriving in the emergency department through the urgent treatment centre. [Regulation 17: Good governance]

Action the trust **SHOULD** take to improve:

- The trust should ensure that there is sustained improvement to 4 and 12 hour target performance.
- The trust should ensure that there is a sustained reduction in ambulance handover times.
- The trust should ensure that there is sustained improvement to the flow of patients out of the emergency department to speciality services.
- The trust should work with system partners to improve patient flow through the urgent emergency care pathway.

Queen's Hospital medical services (including older people's care)

Action the trust **SHOULD** take to improve:

- The trust should continue working on recruitment and retention of both nursing and medical staff.
- The trust should continue working on optimising hospital flow and taking any necessary steps which are in their control to improve flow.
- The trust should ensure that communications between staff when transferring patients during operation snowball, includes the interface between electronic records and paper records.
- The trust should ensure that the utilisation of the discharge lounge is improved.
- The trust should continue working on reducing the waiting lists for specialist medicines.
- Although all the areas we visited were visibly clean, the trust should continue working to improve the consistency for hand hygiene compliance in MRU and Sky A.
- The trust should ensure that therapy equipment is stored in a location more convenient for therapy staff to access.

King George Hospital urgent and emergency services

Action the trust **MUST** take to improve:

- The trust must ensure that they improve oversight of time to triage of patients arriving in the emergency department from the urgent treatment centre. [Regulation 12: Safe care and treatment]
- The trust must ensure all patient records are accessible to admitting wards and there is no possibility of duplication medications. [Regulation 12: Safe care and treatment]
- The trust must ensure that medications are prescribed and administered in a timely manner. [Regulation 12: Safe care and treatment]

Our findings

Action the trust SHOULD take to improve:

- The trust should ensure that they work with system partners to improve patient flow through the urgent emergency care pathway.
- The trust should ensure that there is sustained improvement to 4 and 12 hour target performance.
- The trust should ensure that there is sustained improvement to the flow of patients out of the emergency department to speciality services.
- The trust should ensure that sufficient and appropriate levels of consultant cover for the paediatric emergency department.
- The trust should ensure that appropriate food is available for patients who stay in the ED for extended periods for example, vegan food.

King George Hospital medical services (including older people's care)

Action the trust MUST take to improve:

- The service must ensure that all patient records and assessments are completed accurately and in a timely manner and action plans are clearly identified. [Regulation 17: Good governance]

Action the trust SHOULD take to improve:

- The service should ensure that good standards of infection prevention control and hand hygiene are maintained throughout the service in accordance with their improvement plan.
- The service should continue to monitor and implement action plans identified through their audit programme and ensure measures and outcomes from audits are reviewed regularly.
- The service should improve the response from the maintenance team so that call bells are repaired as soon as a default is reported.
- The trust should develop staffing reporting tools that are able to provide site specific information to monitor site specific sickness rates, vacancy rates and turnover rates for both medical and nursing staff.
- The trust should continue working on recruitment and retention of both nursing and medical staff.
- The trust should continue working on optimising hospital flow and taking any necessary steps which are in their control to improve flow within the medical care service.
- The trust should continue working on reducing the waiting lists for specialist medicines.

King George Hospital diagnostic imaging service

Action the trust MUST take to improve:

- The trust must ensure there is adequate information for Radiology staff on the role of the Radiation Protection Supervisors (RPSs), as well as support and structure for RPSs to fulfil their roles. [Regulation 18: Staffing]
- The trust must ensure that a clinical harm review is completed as soon as possible in regard to the accuracy of patient tracking list (PTL) data for diagnostic imaging patients. [Regulation 17: Good governance]

Our findings

Action the trust **SHOULD** take to improve:

- Managers should reinstate a consistent programme of repeated audits in the Radiology Department to monitor improvement over time.
- The trust should consider potential emergency evacuation procedures for the radiology department.
- The trust should put actions in place to decrease waiting times for patients to access diagnostic imaging.
- The Radiology Department should review the clinical guidelines and policies on the departmental intranet, and institute a quality and version control process.
- The Radiology Department should consider what patient information should be available in communal waiting areas and ensure it is regularly updated curated.

Is this organisation well-led?

We rated well-led as requires improvement.

Leadership

Senior leaders had the skills and abilities to perform their roles. They understood and managed the priorities and issues the trust faced. They were visible and approachable to staff and patients.

The trust had seen significant turnover of staff at Board level in recent years, including the short-term appointments of several interim chief executive officers (CEO). The current CEO, Matthew Trainer, had been appointed in August 2021 into a permanent position. The trust had since appointed additional executive and non-executive substantive directors into key Board level roles and were subsequently making changes to systems and governance processes. There was a priority to build stability into the leadership team and we found that this was beginning to positively impact the culture across the organisation. The CEO and their model of inclusive leadership was cited by many as being significant to this.

The trust had recently entered into a collaborative with another neighbouring NHS acute trust within the same integrated care system (ICS) of North East London. The neighbouring NHS trust had in place a group model of leadership and the CEO of BHRUT was also appointed the deputy CEO of the group. The Rt Hon Jacqui Smith had been appointed chair in common across both trusts in October 2021, who in turn had appointed two vice chairs – one of whom had sole oversight of BHRUT, and the other oversight of the other trust. Three other non-executive directors (NEDs) were providing their skills and abilities collaboratively at both trusts. For example, one NED jointly chaired the individual Quality Assurance committee at both trusts.

The trust Fit and Proper Persons Policy (FPPR) was issued in 2017 and updated in 2022. During the inspection we reviewed the personnel files of Board members and found that all files were in line with the requirements of the fit and proper persons regulation. The trust company secretary was responsible for overseeing annual checks on staff.

The Board at BHRUT was made up of eight executive directors, seven NEDs and two associate NEDs. The executive team included - in addition to the CEO - a chief nurse who had been in post since 2016, and a chief financial officer (CFO) who had been in post since 2019. The CFO told us that he had announced his intent to retire from the trust in March 2024. As part of the exit strategy and succession planning, the CFO had given more responsibility for financial management to the director of finance.

Our findings

The trust had recently made substantive executive appointments that included a chief medical officer and a director of strategy and partnerships. The director of workforce was the one interim executive who remained in post, since 2021. A permanent executive chief operating officer (COO) had not yet been appointed. The absence of this role was mitigated by two interim COOs, who shared oversight of this portfolio of responsibility. For example, one interim COO was responsible for the elective pathway, whilst the other the emergency pathway.

The Board recognised that more needed to be done to promote diversity across executive and senior leadership and, at the time of our inspection, a chief people officer was about to commence their role with the trust. This appointment was considered significant towards addressing and improving equality, diversity and inclusion (EDI) as the individual came with significant experience.

The board of directors were open and honest about the challenges the trust faced. They described themselves as on a continuing journey to improvement and the same time were proud of what the trust was achieving under the leadership of the current CEO. There was a strong sense of teamwork and despite the challenges the trust faced, morale among the Board was high.

The trust executive team were based at the larger of the two hospitals, Queen's Hospital, which saw most of the activity. However, King George Hospital (KGH) was becoming increasingly busier and as part of the plan to improve leadership and governance at KGH, the trust had appointed a site hospital director and a director of nursing. A site-based managing director was also soon to commence. In addition, a new structure was to be introduced with the aim to improve site-based leadership and clinical governance across the trust.

The trust had operated six clinical divisions each run by a clinical director, a divisional nurse and a divisional manager. Changes to this structure would see the proposed implementation of five clinical care groups. Board members acknowledged that leadership at this level needed to be further developed. The new structure was scheduled to be fully implemented by March 2023.

Vision and strategy

The trust had a vision for what it wanted to achieve and was developing a strategy to turn it into action, through engaging with relevant stakeholders. The vision and strategy were being developed with a focus on sustainability of services and alignment to local plans within the wider health economy.

The trust had in place a quality improvement (QI) framework that had been developed through a collaboration with a third party, supported at the time by NHS Improvement. The framework, The PRIDE Way, had been in place since 2015 and was designed to provide a strategic approach to improving care delivery and underpinned the design of existing operational plans. During previous inspection, we had found that The PRIDE Way had had a mixed response and impact on driving improvement within the trust. On this inspection, executive leaders acknowledged that although this framework still drove quality improvement in some parts of the organisation, the trust needed to redesign its strategy. This would need to incorporate the different collaborative relationships the trust now had, including with the neighbouring acute NHS trusts, the Integrated Care Board (ICB) and the associated Place Based Partnerships (PBPs) that had recently been established within the ICS.

The trust had appointed a director of strategy and partnerships to lead on the development of the trust's wider strategy. Conversations with the Board confirmed that there was a joined-up approach to developing this strategy and it was evident that this was being done in partnership with key stakeholders across the ICS, with a focus on tackling health inequalities across the system. Albeit it was still at an early stage of development.

Our findings

In the interim, the trust had published their goals for the coming year that reflected current organisational priorities of delivering high quality, patient centred care; creating a diverse and inclusive workplace; prioritising the sustainability of services; improving performance and establishing financial stability. Leaders were able to describe and discuss these priorities.

The trust continued to prioritise the waiting list backlog that had built up due to the recent COVID pandemic and was able to evidence that the longest waits to be seen had now been addressed. There had also been significant investment in developing community diagnostic services, and the installation of two extra theatres at King George Hospital. However, challenges remained that negatively impacted the patient experience of those using urgent and emergency care at both hospitals. This included overcrowding, delays in treatment and discharge. The trust had introduced strategies to prioritise patient safety, but our inspection of the emergency care pathway highlighted significant concerns, including challenges within the wider health and social care system that impacted this.

The trust's collaborative relationship with the neighbouring acute NHS trust had allowed for improvements across some services with the sharing of skills and expertise, including improvements in governance. This relationship was still being developed with the vision and aim that working collaboratively together would better help address health inequalities, variation in outcomes, improve access to services, and help alleviate workforce pressure across the system.

The trust had developed plans to manage and mitigate the operational pressures during the 2022/23 winter months. However, this operational plan stood in isolation to the wider system of which the trust was strategically dependent on and there was concern that some parts of the system did not have the capacity to be responsive. This potentially negatively impacted patients. For example, the issues regarding access and flow that we found within the emergency care pathway were made worse by issues with primary care, adult social care and community care within the wider system.

The trust had renewed its nursing, midwifery and allied health professionals (AHP) strategy (2021- 2025) which clearly outlined priorities focused on improving patient outcomes, patient safety, learning, communication and engagement, as well as a focus on improving the development and experience of staff working at the trust. The trust had seen a steady increase in substantive staff numbers and a decline in attrition, although more time was needed to establish the impact of the strategy on both staff and patient experience.

The trust had invested into redesigning and refurbishing the emergency department (ED) at King George Hospital (KGH), including specific investment into the children's ED. Other investment into KGH included modernising and increasing the capacity of the intensive therapy unit (ITU) and updating key diagnostic equipment within the radiology department; for example, by replacing the two MRI scanners. Whereas, at Queen's hospital a similar project to update and increase the capacity of the ITU had also taken place.

Culture

The trust leadership were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and were developing opportunities for career development. The trust was fostering an open culture where patients, their families and staff could raise concerns without fear. However, some staff did not always feel respected, supported and valued.

The leadership team were open and spoke candidly about the challenges the trust faced. The CEO was cited by many as being influential in creating an open and inclusive culture. Morale among the senior leadership was significantly

Our findings

improved compared to previous inspections and there was a sense of teamwork and confidence now that there was more stability within the executive team. This included an improved, more collaborative ownership of the financial challenges the trust faced. We also found several examples of where morale had significantly improved among staff across the services we inspected. Although we also found examples of where it was not.

The trust's performance in the latest NHS staff survey (2022) was 'much worse' or 'worse' for half of the indicators, and 'similar' for the other half when compared to other NHS trusts. Less than half of staff completed the survey with 17% saying they had experienced discrimination from another colleague. Trust leaders provided evidence that staff morale had improved since the last staff survey, however despite this the leadership acknowledged that there was still much to be done and anticipated that the next staff survey would likely reflect incremental improvement.

Some junior doctors described a poor experience in training where some issues raised included sexism, discrimination, bullying and undermining behaviour. Senior leaders considered that some of this behaviour was allowed to persist due to the previous instability within the executive team. Junior doctors commented that now there was a more established executive leadership, there had been an improvement in support and issues raised were beginning to be addressed.

The guardians of safe working hours actively advocated on behalf of junior doctors and compiled quarterly reports to inform the Board on matters such as exception reporting, challenges with the IT infrastructure, and other pressures experienced by junior doctors. There had been concern that progress on addressing issues had been slow, however the Board had recently expressed a firm intent to address the concerns that junior doctors raised; particularly inappropriate behaviour from some senior clinical staff and was engaging with staff across the trust accordingly.

The Board was prioritising an agenda of equality, diversity and inclusion (EDI). Workforce Race Equality Standards (WRES) data and Workforce Disability Equality Standard (WDES) data had shown some progress; however, data suggested that experience of BAME staff and staff with disabilities remained poor. There was also poor representation of BAME staff at senior leadership level. The recent appointment of an executive chief people officer was considered key to driving improvements as they brought with them extensive EDI experience.

The current Freedom to Speak Up (FTSU) guardian had worked to promote the service, meeting with staff more regularly, which was evidenced through more staff using the service and more robust reporting to Board. The FTSU guardian had also begun sitting on the People and Culture Committee which would further highlight the issues raised. Staff feedback confirmed that the FTSU service was more effective and concerns staff raised were better acted on by the trust.

The trust operated several staff networks. This included BAME, LGBTQ+, women's, men's, and 'ability not disability' networks. The networks were aimed at highlighting issues, improving awareness and culture, as well as ensuring that these informed the Board. Each network was now represented by a senior person from within the organisation. The People and Culture Committee met quarterly, and the network chairs attended on behalf of the networks they represented.

The trust employed over 8000 staff, and 52% of staff identified as BAME. The trust recognised that this demographic was not reflected in the senior leadership of the trust and steps were being taken to address this, which included better representation of BAME staff on recruitment panels, increasing diversity champions, as well as introducing initiatives such as reverse mentoring. We were told that a workforce strategy to address the wider issues of equality, diversity and inclusion was still in development.

Our findings

Trust wide sickness levels at the time of inspection were 4.2%. The trust had in place supportive strategies to manage staff sickness and had strengthened their approach to supporting staff during the pandemic. The top current reasons for staff sickness were given as musculoskeletal, psychological, and thirdly COVID. Staff recruitment and retention had generally improved, and it was cited that 90% of student nurses went on to be employed at the trust. However, there were areas within the trust that remained difficult to recruit and retain staff to. The location of the trust at the edge of North East London was also considered a factor that impacted staff recruitment.

Governance

Senior leaders were reviewing and redesigning governance processes throughout the trust and with partner organisations. The executive and non-executive team were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of trust services.

The trust operated six clinical divisions. These were: Acute and Critical Care Medicine, Cancer and Clinical Support (including outpatients), Frailty and Geriatrics, Specialist Medicine, Surgery, and Women and Child Health. Non-clinical support services included communications and engagement, estates and facilities, finance, information technology, people and organisational development, and performance.

The trust had redesigned the clinical division structure. There were now to be five clinical care groups, with surgery, critical care and anaesthetics creating one group. Each care group would report to the chief operating officer (currently a post filled by two interims) The new structure was to be implemented by March 2023.

The trust operated a committee structure that informed the Board regarding matters of safety and performance. This included the Trust Executive Committee, Quality Assurance Committee (QAC), Audit and Risk Assurance Committee, and the Finance, Investment and Performance Committee. There were other groups that informed these committees, such as the Quality Governance Steering Group and clinical quality review meetings that took place with the trust's commissioners and other stakeholders.

The QAC was chaired by a NED who also chaired the QAC at the neighbouring acute NHS trust, an appointment made as part of the collaborative group working between these two trusts with the intention that it would overall improve quality assurance governance. The chair of the QAC had been in role since August and recognised that they were still in the process of evaluating the existing governance structure and its effectiveness in monitoring quality and risk.

Quality assurance data was collated and received by the QAC via dedicated dashboards. The dashboards had been further developed and improved and helped ensure data was clear and accessible. A process of monitoring took place through the quality governance structure within the trust which included the Quality Governance Steering Groups, sub-groups and the Divisional Quality and Safety Groups.

The trust Board received assurance about financial control and delivery through the Finance, Investment and Performance Committee and the Audit and Risk Assurance Committee. The chairs of both these committees had appropriate experience of senior financial leadership.

The Audit and Risk Assurance Committee met bi-monthly and had the role of ensuring the integrity of financial reporting and audit process and to oversee the maintenance of sound internal control and risk management systems. The internal auditors confirmed that there had been continued improvement, and together with explicit support from the Board, there was now a more financially focused culture within the trust and better overall grip. However, it was considered that there remained inconsistency with how risk was escalated across wards and divisions. Variability was recognised and the trust was improving how it responded and acted on this.

Our findings

Management of risk, issue and performance

Senior leaders and teams used systems to manage performance. However, they did not always identify and escalate relevant risks and issues, and initiate actions to reduce their impact, in a timely way. The effectiveness of divisional risk management and oversight was variable. There was improved engagement from senior staff in understanding the financial challenges.

The trust set out the most important strategic risks facing the organisation using the Board Assurance Framework (BAF). Broadly, these were quality and safety, workforce, finances and performance. The BAF was considered at the different committees and was regularly reviewed by the Board to ensure that the risks were relevant and there was strategy in place to address them. There was scope for recorded actions to mitigate risks to be clearer and more focused. It was also identified that some risks remained on the BAF without change for long periods of time. Gaps in control and assurance were presented to the Board, discussed and analysed and used to drive the agenda for the Board and the associated committees. Senior leaders were appropriately trained and experienced in risk management. The organisational risks they discussed were reflected in the BAF. However, the trust risk management strategy (2019 to 2022) had been due for review since January 2022.

The reported risks on the trust-wide risk register and high-level risk registers (containing risks scoring 15 and above) were monitored via the Quality Governance Steering Groups and the sub-groups, and the Divisional Quality and Safety Groups. At Board sub-committee level, risk management was managed via the Risk and Compliance Group which was responsible for examining risk management at division and specialty level. However, although managers of the services we inspected generally had a good understanding of risks to their services, and core service risk registers we reviewed evidenced that recorded risks were appropriately owned and managed, it was not clear whether risks to services were always clearly identified and whether divisions were reporting consistently. The QAC chair recognised that greater scrutiny of risk management at divisional level was required.

The trust collated risk and performance into integrated reports that would inform the Board. Trust Board minutes demonstrated that the reports and the data within were discussed. Themes and trends were identified, and outcome measures were RAG rated. Senior leaders recognised that although the integrated reports were comprehensive, they were overly large and needed to be more concise, hence the risk that key information could be overlooked. Senior leaders suggested this could be improved through staff training in how to better utilise these reports.

The trust monitored performance across clinical divisions using digital systems. These informed integrated dashboards so that performance data could be understood in real time to drive safety and quality. This was mostly clear to understand and facilitated teams to be responsive.

Specific core service data requested during our inspection was not always easily interpreted. Systems for gathering site and service specific information to monitor data, such as sickness rates, vacancy rates and turnover rates for both medical and nursing staff, could be improved.

The trust hospital sites had long standing challenges within urgent and emergency care; including triage and streaming, ambulance turnaround times, overcrowding and long waits to be seen or transferred out. At the time of our inspection, urgent and emergency care was under exceptional pressure. The trust had made it a priority to improve flow along the urgent and emergency care pathway. However, our recent inspection found significant concerns remained about the length of stay for patients within the emergency department and that this impacted patient safety and experience. A Letter of Serious Concern was addressed to the trust from the Commission regarding these matters and the trust responded with an appropriate action plan.

Our findings

The trust provided evidence that there was a significant number of mental health patients waiting for long periods of time in cubicles waiting in turn for appropriate mental health inpatient beds to become available. We found that this was a significant issue of concern with 42 people waiting more than 36 hours in the emergency department in October alone. The trust also provided evidence of a bottle neck being met when discharging patients out of the hospital into adult social care in the community, which in turn impacted overcrowding and delays in treatment along the urgent and emergency care pathway.

Following our inspection, a wider system response from key stakeholders was instigated, with the purpose of ensuring collaborative support to address the concerns that impacted access and flow through the urgent and emergency care pathway.

The trust had a history of financial challenge and was subject to a high level of scrutiny through NHS England's Oversight Framework segment 4. The trust had an underlying financial deficit assessed at approximately £98m. The collaborative relationship with the neighbouring acute NHS trust meant that they had worked together to better understand the drivers of this deficit, identifying that approximately £49m related to opportunities to improve internal efficiency and a further £49m related to strategic issues; for example, high insurance premiums, and the challenge of providing medical training across the trust's hospitals.

The trust told us that waste reduction and efficiency programmes were focussing on reducing the numbers of agency staff and the premium costs of temporary staff. Indications were that there was better compliance with financial regulations and that improved business intelligence dashboards, some in real time, were supporting improved decision making. However, activity and workload pressures meant that the trust continued to be financially challenged.

The work of the Audit and Risk Assurance committee incorporated oversight of clinical risks and clinical audit as well as ensuring the integrity of the financial reporting, audit process and oversight of internal controls and risk management systems. The committee chair recognised that restructuring of divisions and subsequent improvement of governance would potentially improve the management and oversight of risk and performance. The trust's relationships with internal and external auditors were generally described as helpful.

The external auditor had identified that controls over the trust's PFI contracts had not been sufficient. Although the trust had made its unitary payments annually, it had not ensured that the managed equipment replacement programme was delivered in line with the contract. In consequence, there were instances where the planned replacement cycles had been missed, and that payments made had not been applied to the purposes intended.

The trust had identified features from the initial design of buildings that led to difficulties in delivering the necessary enablement works to support equipment replacement whilst maintaining emergency services; but documentation appeared incomplete. In consequence, equipment replacement cycles had slipped. The trust told us it was working with the equipment manufacturer to recover the position. The trust had also undergone a successful market testing exercise to reduce costs on soft facilities management.

Information management

The trust collected data and analysed it. The trust was improving the way staff could find the data they needed in more easily accessible formats, to understand performance, make decisions and improvements. However, the current information systems were not well integrated, and the use of paper records meant that patient's records were not completely secure. Data or notifications were consistently submitted to external organisations as required.

Our findings

The trust was the only acute NHS trust in London that did not have a system of electronic patient record keeping (EPR). The trust was developing a business case and told us that, as part of group working with the neighbouring NHS acute trust, clinical information teams were supporting the development of this, as well as sharing IT advice and experience. It was expected that additional capital funding would be required. Once the procurement process was complete, it was expected that it would be 2025 before the implementation of EPR was commenced. However, the trust was working in advance to identify the associated risks and planning how to mitigate them.

Staff spoke of the challenge and risks associated with not having an EPR and the use of several different existing systems that were not integrated. We heard several examples of where obtaining patient's paper notes had been delayed, or where requests for imaging or other referral either took time to complete or delayed doctors from addressing other tasks.

The poor integration between systems within urgent and emergency care exacerbated the already poor interface between the urgent treatment centre (UTC – ran by a different provider) and the ED, putting patients at risk of not receiving care in a timely way. While our inspection of diagnostic imaging at King George hospital raised concern that a regular process for auditing the quality and accuracy of information in patient records, including imaging quality, was not sufficient.

Concern was also raised that a system for electronic prescribing and medicines administration (EPMA) could not be installed until the EPR was implemented. The absence of an EPMA was cited as being a reason why recruitment into pharmacy posts within the trust was difficult.

Senior leaders raised concern regarding connectivity issues within the Queen's Hospital site. A two-year programme to install an upgraded communications system (including Wi-Fi) across the trust was funded to address this. Led by the information management and technology team (IM&T) this was to commence in the near future.

The trust business intelligence team identified in July 2022 that there was a discrepancy with the reported monthly diagnostic activity levels and waiting times (known as DM01). This came to light following the replacement of the Radiology Information System (RIS) that had been installed in October 2021. This impacted approximately 8000 patient's imaging requests that had not been actioned in relation to routine MRI, ultrasound and CT scans.

The trust declared a serious incident in August 2022 and immediately commenced a process of validating the data to confirm the accurate number, which subsequently was identified to be around 4000 individuals. The trust contacted patients and put in place actions to reduce the backlog of patients waiting, which included outsourcing to third-party providers. A clinical harm review that was tailored to consider an assessment of harm against the length of waiting times was proposed, although this had not commenced at the time of our inspection and the trust were unable to give assurance as to whether patients had been harmed or not as a result of this incident.

Following our inspection, the trust confirmed that they had commenced a process of reviewing a representative sample of scans, focusing on a sample of 100 individuals who had waited the longest. Out of the 100 scans reviewed, 28 showed significant findings and it was clinically agreed that three were scenarios where a delay in diagnosis had the possibility of affecting prognosis, although it was also evident that each of these individuals had received appropriate care. Duty of Candour letters were being sent to each patient with a positive finding where there had been a delay. The trust informed us that further validation had reduced the number of patients impacted to 1,231. Of which all were to be subject to a patient harm review.

Our findings

The trust had a Caldicott Guardian and a Senior Information Risk Owner (SIRO), both roles filled appropriately by executive directors. The trust submitted their Data Security & Protection Toolkit and were assessed as providing 'significant assurance with minor improvement opportunities'. The identified areas for improvement had been addressed.

Engagement with public, staff and external partners

Senior leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust's performance in the latest CQC inpatient survey (2021) was 'Much worse' or 'Worse' for six of the eight questions. Areas highlighted by the survey pertained to pain control, respect and dignity, and speaking about fears and worries. Inpatient survey pertaining to patients with dementia and learning difficulties showed improvement in the quality of care.

The trust launched the Patient and Carer Experience Strategy for 2021/25 in June 2021, with a focus on improving partnership working with patients, whilst recognising increasing pressures due to an ageing population, increasing costs associated with delivering healthcare, and increasing public expectations. Progress on the delivery of the strategy was monitored by the Patient Experience and Engagement Assurance Group who through the committee structure, informed the Board. The trust's Patient Partnership Counsel was one way in which patient and carer's views relating to the service and care they received was collected.

The trust had developed a learning disability (LD) strategy, codeveloped with patient and carer groups. Staff mandatory training for LD had been improved and there was good staff compliance. LD patient deaths were each individually subject to thorough review.

The patient advice and liaison service (PALS), incorporating a team to manage complaints, had improved their engagement with patients and carers, seeking to manage complaints and concerns as they unfolded. This had seen a drop in formal complaints made to the trust. Management of complaints was prompt and all complaints in the year to date (Oct 2022) had been addressed within the agreed timeframes. The trust had further planned to better monitor the demographics of complainants (such as protected characteristics) and identify learning to help drive improvement.

The trust was engaging with different population groups in the community, collaborating with other partner organisations and stakeholders to provide outreach services to hard-to-reach people groups. The trust was also involved with the People with Lived Experience Charter and had been selected based on the voluntary work taking place to improve access to opportunities for local vulnerable and disadvantaged young people. The aim of the programme was to improve the recruitment and retention of a larger, more diverse workforce. The trust was the only acute NHS trust involved in the programme and were acknowledged for demonstrating inclusion and diversity for young people.

The trust had facilities and programmes to support the education, training, learning and development of staff. A preceptorship programme developed collaboratively with a local University, offered a 12-month accredited programme for newly registered nurses, nursing associates, midwives and AHPs; including overseas trained practitioners and those returning to practice. The programme had been positively received by staff and had improved staff retention.

The trust had put in place initiatives to support staff during the COVID pandemic and had now further established and extended this support to staff facing current cost of living challenges, such as providing vouchers to enable families to buy school uniform and access to free period products.

Our findings

The trust recognised that instability of senior leadership over recent years had allowed certain attitudes and behaviours to go unchallenged. Senior leaders were focused on addressing this and were improving the way they engaged with staff; including consultants, trainees, and clinical and divisional leads. Increased engagement was also helping to identify which departments within the trust needed investment to improve morale and team working.

Board members carried out walkarounds, visiting clinical areas and meeting staff and patients across the trust's hospital locations.

The Board talked positively about the collaborative relationship with the neighbouring acute NHS trust and how this was mutually supportive. Both trusts were also part of an acute provider collaborative with a third acute NHS hospital foundation trust within the North East London ICS. The Board described how this relationship was also helping support improvement of key services.

The appointment of an executive director of strategy and partnerships meant that there was proactive engagement with stakeholders internally and externally across the different collaboratives, including with the recently established Integrated Care Board within North East London. This was helping to identify the key strategic priorities that would shape the trust's role within the integrated care system.

Learning, continuous improvement and innovation

Senior leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust recognised that to be able to address the larger challenges they faced, an innovative and collaborative approach was necessary. With priority on reducing waiting times, the trust had introduced 'super weeks' and 'super clinics.' For example, Project Scalpel saw 1001 patients prepped for surgery over six Saturdays and over 3000 ophthalmology patients were seen over four 'super' weeks.

The collaboration with the neighbouring acute NHS trust had a shared positive impact, for example with each providing support to the other, such as in supporting emergency care, critical care (as seen during the pandemic) and elective care. The two trusts were also working together as part of the North East London cancer alliance which had seen improvement in the timely delivery of cancer care post the COVID pandemic.

The trust had introduced initiatives to improve patient care and experience, such as the ward accreditation programme. Several trust quality improvement initiatives had received national recognition. This included providing career opportunities for vulnerable, disadvantaged young people (as part of the People with Lived Experience Charter); a project aimed at helping children learn to live healthier lives; an organisational and development initiative training doctors from overseas; and the introduction of a voluntary service aimed at providing added support for patients and carers during palliative care.

The chief nurse fellow programme, introduced in 2020, aimed at giving health care support workers, nurses, midwives and AHPs the opportunity to develop their leadership and innovation skills, had impacted 50 staff in the first year and was already running for a second year with positive feedback.

Our findings

The trust was affiliated to the London clinical research network. Through its local acute provider collaborations, the trust was looking to benefit from shared learning and experience that would expand its research portfolio. Senior leaders spoke of the unique opportunities offered due to the diverse demography the trust served.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↔ Feb 2023	Good ↔ Feb 2023	Good ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↔ Feb 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
King George Hospital	Requires Improvement ↔ Feb 2023	Good ↔ Feb 2023	Good ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↔ Feb 2023
Queen's Hospital	Requires Improvement ↔ Feb 2023	Good ↔ Feb 2023	Good ↔ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↔ Feb 2023
Overall trust	Requires Improvement ↔ Feb 2023	Good ↔ Feb 2023	Good ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↔ Feb 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for King George Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Feb 2023	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Requires improvement Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Requires improvement Jan 2020
Critical care	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
End of life care	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Surgery	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018
Urgent and emergency services	Inadequate ↓ Feb 2023	Not rated	Not rated	Inadequate ↓ Feb 2023	Requires Improvement ↔ Feb 2023	Inadequate ↓ Feb 2023
Outpatients	Requires improvement Jan 2020	Not rated	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Good Jan 2020
Diagnostic imaging	Good Feb 2023	Not rated	Good Feb 2023	Requires Improvement Feb 2023	Requires Improvement Feb 2023	Requires Improvement Feb 2023
Overall	Requires Improvement ↔ Feb 2023	Good ↔ Feb 2023	Good ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↔ Feb 2023	Requires Improvement ↔ Feb 2023

Rating for Queen's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Critical care	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
End of life care	Good Jan 2020	Good Jan 2020	Good Jan 2020	Outstanding Jan 2020	Outstanding Jan 2020	Outstanding Jan 2020
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018
Urgent and emergency services	Inadequate ↓ Feb 2023	Good Jan 2020	Requires Improvement ↓ Feb 2023	Inadequate ↓ Feb 2023	Requires Improvement ↔↔ Feb 2023	Inadequate ↓ Feb 2023
Maternity	Requires improvement Oct 2021	Good Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Oct 2021	Requires improvement Oct 2021
Overall	Requires Improvement ↔↔ Feb 2023	Good ↔↔ Feb 2023	Good ↔↔ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↔↔ Feb 2023	Requires Improvement ↔↔ Feb 2023

Queen's Hospital

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Tel: 01708435000
www.bhrhospitals.nhs.uk

Description of this hospital

Queens Hospital is the trust's larger acute hospital and opened in 2006, and serves the population of Havering, Barking, Dagenham, and Brentwood, as well as other surrounding areas.

Queen's hospital includes an emergency department (ED), medical speciality wards including a hyper acute stroke unit (HASU), surgical wards and theatres, maternity and obstetric services, intensive care and high dependency units, and services for children and young people.

In December 2021, we sent the trust a letter of serious concern following a focused inspection of emergency department (ED) care at Queen's Hospital. Following that inspection, the team found significant concerns with the streaming and triage processes; the length of stay for patients within the department and subsequent overcrowding, ambulance handover times, and the delayed flow of patients from the hospital into the community. The Commission acknowledged that some of the issues the trust faced were complicated by wider challenges within the local health and social care system. The trust responded with action plans for improvement and this was followed up through reviews and engagement.

On this occasion, we extended the inspection to the emergency and medical divisions at both trust hospitals and we also inspected the well-led key question for the trust overall. Our unannounced inspection was conducted in the same week as an unannounced inspection of the urgent treatment centres (UTC) on both hospital sites. These UTCs are operated by another provider and are reported separately.

Although we saw improvements in staffing, local leadership and culture, we found further deterioration in interfaces between the ED, UTC and ambulance services, compounded by delayed admissions of patients to speciality services and social care.

Waiting times and patient flow through the department continued to be a significant concern and the corridor care we saw was unacceptable from the perspective of dignity and privacy. Other key aspects such as the use of incompatible computer systems also contributed to the delays and increased the risk of error.

After the inspection we told the trust and the UTC provider they must make improvements.

Our findings

Summary of urgent and emergency services at Queen's Hospital:

- The trust faced continued challenges with access and flow which meant they could not always ensure patients accessed the ED when needed to receive timely treatment. Data we reviewed confirmed delays in patients waiting to be seen and receiving treatment. This included delays in ambulance handover.
- The trust did not have complete oversight of how long walk-in patients from the UTC had been waiting to receive care. Some patients were not prioritised according to their clinical need or history and lack of flow through the ED contributed to delays in identifying and acting upon patients at risk of deterioration.
- Patients were not always cared for in the best place for their treatment needs. We saw patients being cared for in an open corridor, where there was no provision for preventing public access to the corridor or use of portable curtains or call bells. This meant patient privacy or dignity could not be maintained.
- Patients in the ED could not be moved promptly to specialist wards or mental health facilities due to lack of capacity within those areas. Challenges with access and flow often resulted in demand exceeding the safe level of occupancy within the department.
- Overcrowding of patients and relatives in the department and access corridors presented an increased risk of nosocomial infection where patients, staff and visitors congregated.

However:

- Equipment and the premises were visibly clean.
- Staff, while under pressure, worked hard to provide care to patients and meet their individual needs.
- Staff and managers were committed to improving services under their control.
- Leaders were aware of the challenges within the department and had worked to resolve them.

Summary of medical services (including older people's care) at Queen's Hospital:

- Services had enough staff to care for patients and keep them safe and the service controlled infection risk well. Staff managed medicines well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The trust planned care to meet the needs of local people and engaged well with other health care providers and system partners to plan and manage services.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Most staff felt respected, supported and valued.

However:

Our findings

- Although the trust continuously worked on initiatives to improve flow with projects such as Operation Snowball, FOPALS team and Red2Green Team, the sheer patient volume and complexity was challenging. Senior leads told us that system issues such as obtaining nursing home placements and social care packages (especially for out of area patients) contributed to delays in discharge.
- Managers monitored waiting times; however, patients could not always access services in specialists medicines such as neurosurgery when needed due to theatre capacity. Divisional leads told us that although the population the trust served had increased and continued to do so, the hospital's capacity remained the same.

Urgent and emergency services

Inadequate ● ↓

Is the service safe?

Inadequate ● ↓

Safeguarding

Staff understood how to protect patients from abuse and the service worked with community services and other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role and knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw posters on display indicating who to contact in the trust's safeguarding team and staff told us how they made safeguarding referrals should they have any concerns .

Data provided by the trust showed that divisional training compliance for safeguarding at level 4 was 100% and compliance figures were all above trust targets for adult and children levels 1-3.

Staff said the ED safeguarding lead was supportive and approachable with any concerns they raised. Managers explained that the safeguarding lead reviewed the records for all children who attended the paediatric emergency department.

Staff followed safe procedures for children visiting the department. Paediatric patients had their own assessment area pathway within the department. All paediatric patients we saw in the area were accompanied.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Control measures were not sufficient in all areas to protect patients, staff and others from infection. However, staff kept equipment and the premises visibly clean.

National guidance on infection prevention and control (IPC) measures for COVID-19 had changed since our last inspection. The trust followed the latest guidance. Facemask dispensers with prominent warning signs were sited at entry points to the hospital and we saw staff and visitors wearing masks or face shields.

Hand sanitising stations were placed at entry points throughout the hospital and we observed people using these. There were arrangements for enhanced cleaning and we saw operatives cleansing high-touch points such as chairs, tabletops and door handles.

Guidelines recommending best practice were followed, such as those published by the Royal College of Emergency Medicine (Infection Prevention and Control Guidance - October 2022). We saw electronic systems used to help identify vulnerable patients (such as people on chemotherapy) and staff explained the arrangements for segregating people with Coronavirus symptoms and accessing rapid COVID-19 testing.

We saw frequent overcrowding of patients and relatives in the department and access corridors, which meant that social distancing could not be adhered to. This presented an increased risk of nosocomial infection where patients, staff and visitors congregated.

Urgent and emergency services

We noted there was limited distancing between patients who were seated in the 'fit to sit' section of the rapid assessment and first treatment (RAFT) area. We also saw visitors and staff from other areas of the hospital brushing past patients who were lying on stretchers or beds in the main corridor outside the ED.

Despite the overcrowding, we observed efforts made throughout the day to keep areas clean and tidy. Cleaning records were up-to-date and demonstrated that areas were cleaned regularly.

The trust had suitable furnishings which were clean and well-maintained. Staff followed infection control principles including the use of facemasks and wear of short-sleeved clinical uniforms or medical scrubs.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff disposed of clinical waste safely. Needle sharps bins were available throughout the ED and the bins we inspected were labelled and stored correctly.

Environment and equipment

The design and use of some parts of the premises did not always keep people safe.

Opened in 2007, the hospital was designed with ground and first-floor levels comprising diagnostic and treatment services, while the upper levels consisted of a compact four-leaf clover layout for inpatient services. The main building was designed to reduce lengthy corridor journeys for patients and staff. Additional buildings on site included a day nursery, administration building, energy centre, bus station, multi-storey car park and helipad.

Dedicated curb-free entrances with automatic doors were provided at entryways for the UTC, ED and other ground-floor departments.

Access from the main entrance to the ED floor was by a corridor wide enough to allow two ambulance stretchers or hospital beds to pass each other. This corridor led from the hospital foyer through to ED and departments such as radiology, a high dependency unit, intensive care and coronary care units. Outside the RAFT area of ED, the passageway was joined by another corridor leading from the ambulance-only entrance. It was a busy thoroughfare, used by staff and ambulance crews along with patients from other areas of the hospital, relatives and visitors.

The paediatric area was a separate unit to the main department, with its own entrance and reception area. There was a large waiting area within the paediatric area which was well equipped and easily visible to staff. The paediatric area had its own resuscitation rooms which were fully stocked to allow for treatment of children of different ages.

The adult ED floor comprised of a reception area and working spaces designated as resuscitation; majors, the rapid assessment and first treatment (RAFT) unit. The RAFT unit incorporated ambulance receiving bays along with a same day emergency care (SDEC) unit for medical patients. The RAFT also had a section for patients deemed 'fit to sit'.

Patients streamed from the UTC were escorted along the corridor in small groups and we saw hospital volunteers helping to direct patients during the daytime. However, a member of staff described a recent incident at night when a patient had arrived unannounced from the UTC and was found in the main corridor on a trolley bed. This indicated that patients were still becoming lost which increased the risk of delayed treatment or undetected deterioration.

Urgent and emergency services

Following our last inspection, the trust had relocated the ARC from a separate area of the hospital and incorporated it into the RAFT unit. However, the ARC designated bays were insufficient for the number patients arriving by ambulance. This meant patients and ambulance crews were held in the main corridor while waiting for assessment and then moved back into the corridor prior to admission.

Cupboards, corridors and rooms were well lit and uncluttered, although in the main corridor we observed a computer server or switching room with cardboard and furniture stacked next to electric panels. We brought this to the attention of managers, who immediately arranged for the area to be cleared and cleaned.

Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with tamper evident tags. Safety checks were carried out daily.

Assessing and responding to patient risk

We were not always assured there was adequate oversight and responsibility of the patients who were waiting to be seen. Some patients were not prioritised according to their clinical need or history. Staff completed risk assessments and worked to minimise risks, however overcrowding and lack of flow through the ED contributed to delays in identifying and acting upon patients at risk of deterioration.

Staff at the UTC saw all walk-in patients initially who streamed and triaged them, and directed them to the adult or paediatric ED, where they would be triaged a second time.

Waiting times for initial assessment at the UTC were not effectively monitored by the trust and we noted delays which we passed on to our colleagues inspecting the UTC.

Adult patients who were referred from the UTC or arrived by ambulance were seen in the RAFT unit for handover and triage. Here a senior doctor assessed the patient's condition on arrival, ordered any tests, and categorised the patient by severity of presenting complaint, dictating the priority order of seeing the patient in the department.

The RAFT area lacked the capacity to handle the number of patients. We checked on the first evening and found 39 patients in the unit, with the longest waits for a bed at 23.5 hours; 20.5 hours and 16 hours. One patient had been in the main corridor, used as an overflow from the RAFT (ARC) for 9 hours. Overcrowding caused concern. For example in the RAFT we observed a patient who was admitted from UTC at 18:51 with chest pain. He had been streamed at UTC 17:42 without receiving an electrocardiogram (ECG), an important test of heart muscle activity used to help diagnose dangerous heart conditions. The patient experienced a further delay due to overcrowding before he got an ECG in the RAFT. Our inspector was unable to determine the exact time delay as the ECG printout was unclear.

An ambulance receiving centre (ARC) had been created for ambulances to offload patients prior to the patient proceeding through the RAFT area. Originally a 9-bed ARC had been created in collaboration with the ambulance service, who staffed the centre on an agreed basis of 2 crew to 7 patients. The centre was popular with ED staff and crews because the centre helped to release vehicles back into the community. However, the spaces designated for ARC in the RAFT unit were inadequate for the demand, which resulted in patients waiting in the main corridor.

On day one of the inspection, we observed between 5 and 10 patients at any one time in the main corridor lying on ambulance stretchers or hospital beds. We also returned to the department in the evening before departing at around 22:30, when we saw 13 patients in the corridor. Ambulance staff confirmed that up to 21 patients (3 crews) could be held in corridor care.

Urgent and emergency services

We saw less numbers in corridor care on our second day of inspection (between 3 – 7), although we discovered two patients who had been in the corridor overnight for between 9 – 11 hours. One patient told the inspector that he was tired and couldn't sleep because the corridor was noisy and the lights were on. Ambulance crews who were providing corridor care told us this was not unusual.

The waiting area in Majors, for patients awaiting emergency triage, transfer to one of the cubicles or the fit to sit area, became crowded during busier times. Clinical staff carried out a visual assessment of all patients at 15 minute intervals, however long waits still posed a risk to patient safety.

We also saw between 1 - 3 patients at any one time in the junction area of the two corridors, along with ambulance crews waiting for initial triage in the RAFT area. We noted it took between 1 - 2 hours before their patients were assessed and crews released and ambulance crews confirmed this when we asked. This meant delays occurred in investigations and treatment for the patient as well as preventing the crew and ambulance answering other emergency calls.

While we acknowledge that sufficient ambulance staff were provided to keep patients safe while they waited in the corridor, we observed occasions when patients were not always covered properly and exposed to others using the corridor.

We also observed a doctor partly examining a patient in the corridor without the means to adequately protect their privacy and dignity. Incomplete or superficial physical examination increased the risk of miss-diagnosis, unnecessary diagnostic testing or delayed treatment

We saw that 3 bays in the RAFT area had been marked as assigned to the ambulance receiving centre (ARC). These were fully occupied wherever we checked, which meant the bays were not immediately available for use when ARC patients located in the corridor needed personal care or clinical examination. This indicated that the number of bays available was insufficient and may have contributed to observation of a doctor performing a physical examination in the corridor outside. We were told about a recent case that happened with a patient who had an epileptic fit and was treated in the corridor. The patient sustained injuries which were not diagnosed because the patient did not have a proper examination in the corridor.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Electronic observations with National Early Warning Score 2 (NEWS2) were carried out and these results were visible within the department electronic patient record and tracking system. However, staff described how incompatible IT systems between the UTC and ED contributed to delays and increased the risk of error. These were compounded by instances where other systems, such as ordering diagnostic imaging were also incompatible. For example, doctors told us that MRI requests had to be manually taken to radiology.

Staffing

Since our last inspection, the service had increased the numbers of doctors and nurses in the department. On the days of our inspection, we saw enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Assurance of safe staffing in the ED was checked using a safer staffing tool, professional judgement, activity and flow data, and acuity and dependency where applicable.

Urgent and emergency services

Individual patient acuity and overall department patient status were considered three times a day at leadership team huddles called pit stops. These took place alongside regular nurse and medical staff in charge review of patients and the pit stops addressed surge, reallocation of staffing and direction of support to areas of need. We were told that leaders from the UTC attended these pit stops to allow for an understanding of demand across both the UTC and ED, but we did not see a representative on the meeting we observed.

When staffing was not meeting planned levels, the trust would use bank staff or agency staff. All bank and agency staff we spoke with had completed an induction and were familiar with the department.

Managers and staff told us that the establishment for consultants had been increased and additional nurses had been recruited successfully. Junior doctors also told us that there were sufficient numbers on duty and they could access support when needed. However, when we checked the medical rota for the last 2 months, we saw the number of medical staff did not always match the planned numbers. There were no gaps in paediatric consultant cover in the paediatric ED although between 7 – 9 shifts a month were filled through the trust bank. Overnight and weekend 'on call' cover for adult and paediatric consultants was maintained throughout by substantive employees, while night shift consultant cover appeared to be predominantly agency and bank staff. Around 4 night shifts per month were vacant, meaning a reliance was placed on the on-call consultant.

There were gaps in cover for junior doctors. According to the data provided, out of 750 shifts rostered there were 62 vacant shifts in August; 58 in September, 143 in October and 56 in November.

The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings. This meant the department was always staffed with two registered children's nurses. Data showed staff were up to date with appropriate paediatric intermediate life support.

Records

Digital systems did not allow for the transfer of patient information from the onsite urgent treatment centre.

We checked a sample of patient records and saw that individual risk assessments were completed and recorded appropriately. However, when patients were triaged from the UTC to the ED, they had their clinical notes up to that point including a set of observations printed off to take with them.

This meant staff within the ED had to enter patient information onto a new digital system which duplicated data entry and took up additional time.

Patient records were stored in trolleys located around the central nursing hubs. These were kept closed and the ones we checked were locked.

Medicines

The service did not always have systems and processes to safely prescribe, administer, record and store medicines.

Medicine management within the ED was exacerbated by issues with flow resulting in the long length of stay for high numbers of patients within an inappropriate setting. This resulted in increased risks around missed doses of medication and medicines security.

Urgent and emergency services

Medication accompanied patients through the busy ED which exposed the risk of medication being lost or mixed up with other patients medication. Where patients attended the ED with their own medication, this was not stored securely by the trust and instead remained the responsibility of the patient.

Medicines administered by the trust were securely stored in keypad locked rooms.

Room and fridge temperatures in the ED were monitored using an automated data logging system and any changes investigated by pharmacy representatives. Staff described the system in place for any occasions when temperatures exceeded the manufacturer's recommendation. In this case, a red sticker was applied effected medication to bring forward the expiry date by three months.

Is the service caring?

Requires Improvement  

Compassionate care

Although staff treated patients with compassion and kindness, we saw patients being cared for in an open corridor. There was no provision for preventing public access to the corridor or use of portable curtains or call bells which meant that patient privacy or dignity could not be maintained.

On both days of the inspection, we observed between 3 - 10 patients at any one time in the main corridor lying on ambulance stretchers or hospital beds. It was a busy thoroughfare, used by staff and ambulance crews along with patients from other areas of the hospital, relatives and visitors.

Patients were mixed genders and we observed that all were in nightwear or hospital-supplied examination gowns, which were open at the rear. While we saw staff adjusting patient's bedclothes to keep them covered, they became exposed when patients moved or became restless.

When we raised our concerns with local managers, they acknowledged the difficulties and initiated remedial action which included restricting public access to the corridor. After our inspection the trust confirmed the purchase of portable screens, call bells and more electrical sockets for use with hospital beds.

We observed staff and ambulance crews providing compassionate care in the adults and paediatric units where they were able to do so. Staff and managers apologised for keeping patients waiting, despite this being beyond their full control. Staff of all grades told us they found the extended waits for patients and overcrowding within the department distressing.

Patients said staff treated them well and with kindness and that they were happy with the care they received despite their frustrations with the long waits to receive it. Some people told us they were content to wait as long as necessary as they understood they would see a doctor eventually.

Relatives and some patients sought us out to provide positive feedback about the medical and nursing staff, including that of a family with a relative in a specially designed side room for people experiencing a mental health crisis.

Urgent and emergency services

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

In response to extended waits for treatment in the department, the trust had increased the availability of food and drink to patients to be 24/7. We observed frequent food and drink rounds conducted by support staff and patients told us that hot food was provided in addition to vending machines for visitors located in the Majors area.

Is the service responsive?

Inadequate ● ↓

Access and flow

The trust faced significant challenges with access and flow which meant that they could not ensure people were able to access the emergency department when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The team could see on the IT system the length of time patients had been in the ED as well as an overview of bed availability and flow of patients coming into the ED which was discussed at regular bed meetings through the day along with staffing numbers.

Managers and staff worked hard to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was achieved. Many expressed frustration at the challenges presented by lack of capacity in the local health and social care system.

However, delays in admission, transfer or discharge continued to be caused by the combination of significant numbers of patients arriving in the department and, poor flow through and out of the hospital. There was poor flow within other specialties of the hospital as well as a lack of available care in the community for patients to be discharged to. For example, we found delays in transferring patients with mental health needs had an adverse impact on the capacity of the emergency department. We noted adult and paediatric patients with mental health needs among the patients stranded in the ED. The trust subsequently provided data to show that during October and November 2022, they had the equivalent of 10 ED cubicles full for mental health patients.

On the first morning of the inspection, we were told by hospital and ambulance staff that the department was “not busy” in comparison to other days. Despite the favourable start to the day, by 21:25 hours we counted 108 patients in the department.

Majors A had 23 patients waiting for beds, with over 14 patients waiting more than 20 hours for beds. In the RAFT area there were 39 patients with the longest waits for a bed at over 23 hours. One patient had been in the corridor for 9 hours. In Majors B there were 28 patients with the longest wait for beds ranging from 13 – 34 hours.

In Resus, we saw a 78 year old who had been in the department for 45 hours waiting for a bed and another 79 year old who had been in the bay for over 20 hours. At about the same time, in the RAFT area, we found a 30-year-old woman who had been conveyed by ambulance at 18:17 hours with abdominal pain and vomiting. She was placed in the ‘fit to sit’ bay and triaged, soon after arrival, by the consultant, who arranged for blood tests to be taken. However, she did not

Urgent and emergency services

receive pain relief for approximately 3.5 hours from admission nor was seen again by a doctor until 23:00 hours. Blood results showed significant abnormality, but it was unclear who reviewed these or when. We were told by a relative that the patient remained in a chair overnight and was moved to the resuscitation area at 10:31 the next morning. Based on our review of her patient notes she did not have a full physical examination until she was moved to resuscitation. The physical impact on the patient in this instance was prolonged and unnecessary pain and discomfort, delayed differential diagnosis and timely commencement of appropriate treatment, which increased the risk of complications occurring. Overcrowding in the department had also impacted this person's care and comfort.

We observed 10 patients located in the resuscitation area, which had 8 bays, leading to delays in accepting other patients like this individual. We also noted there were several other patients sitting in chairs in the 'fit to sit' bay and that these chairs were sited less than a foot apart from each other, which increased the risk of cross-infection by bacterial or viral contamination.

We also saw between 1 - 3 patients at any one time in the junction area of the two corridors, along with ambulance crews waiting for initial triage in the RAFT area. We noted it took between 1 - 2 hours before their patients were assessed and crews released and ambulance crews confirmed this when we asked. This meant delays occurred in investigations and treatment for the patient as well as preventing the crew and ambulance answering other emergency calls.

We saw that 3 bays in the RAFT area had been marked as assigned to the ambulance receiving centre (ARC). These were fully occupied wherever we checked, which meant the bays were not immediately available for use when ARC patients located in the corridor needed personal care or clinical examination. This indicated that the number of bays available was insufficient and may have contributed to our observation of a doctor performing a physical examination in the corridor outside.

Our observations reflected trust reports about time patients spent in the ED. For example, the trust reported the longest median total time in ED in the London region over five months from April to August 2022 and in March 2022, the trust reported the second longest time in the region. As of August 2022, the trust median was five hours and 39 minutes, compared to the England average of three hours and five minutes.

There was a reduction in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 724 in April 2022, to 513 in May 2022. As of September 2022 the trust reported 567 such waits. Between July 2021 and August 2022 the trust reported 21 serious incidents in ED of which 9 were attributed to delay.

Staff and leaders told us same day emergency care (SDEC) for patients, which is now a mandated pathway for patients and would take patients away from the overcrowded department, was not being used effectively. During the inspection we observed this was the case and the SDEC was not being utilised effectively for its intended purpose.

Patients arriving by ambulance were triaged in the Rapid Assessment and First Treatment (RAFT) unit once they had been registered onto the hospital patient electronic system, unless the patient had to be brought directly to the resuscitation area (resus). At the time of the last inspection we found that there were often periods of overcrowding when ambulance crews were unable to handover the patient and on this inspection we found this was still the case.

During these periods, the corridor was used as extra capacity, where ambulance crews could wait with their patients. The trust had been working with the ambulance services in order to improve ambulance handover times and release ambulance crews back onto the road.

Urgent and emergency services

The ARC was permanently staffed by four ambulance staff meaning crews with applicable patients did not have to wait for handover and could return to the road

However, the ARC had been relocated to cohabit the same space as the RAFT area allowing for a wider range of patients to await handover including out of region ambulance services. The HALO was onsite from 10 am to 10 pm seven days a week. Their role was to ensure the smooth offload of patients into the department, to look after ambulance crew welfare, to liaise with the ED about patients waiting with ambulance crews and to help manage the flow of ambulance patients into the ED.

Ambulance handovers were not in line with standards for an ambulance handover (clinical handover and offload) to be reliably completed within 15 minutes of arrival.

Is the service well-led?

Requires Improvement   

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The trust had an established leadership structure which included divisional directors, divisional managers and divisional director of nursing. Leaders and staff of all grades were open and candid about the challenges the ED faced. Many had strong links with the local community and appeared committed to improvement.

Senior leads understood the challenges to quality and sustainability the service faced and had plans in place to address them. However, some of the challenges related to the wider healthcare system.

Staff told us that they were able to raise concerns as needed. Staff we spoke knew about the freedom to speak up guardians and how to contact them should they need to raise a concern.

Staff we spoke with told us that managers and leaders were visible, approachable and supportive.

Although staff told us that the work pressure was high, staff reported a happy working culture and commitment to improvement.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions.

Hospital flow was recognised by the senior leadership team as a serious risk to the ED's ability to provide safe care and treatment. There was an action plan which focussed on improving this. The plan was updated regularly, and the key interventions were priorities by the trust.

Urgent and emergency services

Risks were discussed at monthly quality and safety meetings where staff could also attend. We saw quality and safety noticeboards sited in prominent places which included information on incidents and learning. Managers explained that ED risks were discussed at the monthly governance meetings and we saw meeting minutes that indicated this. Agenda items included finance, staffing levels, wellbeing, recruitment, risks and issues arising. Meeting had attendance logs and staff confirmed these were circulated by email.

Senior medical and nursing team members had regular meetings with the divisional leadership triumvirate. The service had weekly tracker meetings which reviewed risks, complaints and incidents.

The service mitigated the staffing levels risk by using bank and agency staff. Leaders explained that staffing levels had improved since the last inspection and we saw evidence of this. The establishment for medical consultants had significantly increased and recruitment had been successful.

The trust had a local emergency preparedness policy, which helped to ensure the ED was prepared for unforeseen service interruption.

Medical care (including older people's care)

Inspected but not rated ●

Is the service safe?

Inspected but not rated ●

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean.

The service generally performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas.

The IPC team completed joint divisional audits for geriatrics and specialist medicines on a quarterly basis. The audit assessed the environmental compliance with IPC standards. Data for the care of elderly wards showed that the divisional average for quarter one (April to June 2022) was 90% and 87% for quarter two (July to September 2022). In comparison, data for specialist medicines showed that the divisional average for quarter one was 90% and 86% for quarter two.

Hand hygiene audits were completed monthly by the wards. Data for the care of elderly wards showed the divisional average was 81% in quarter one, 79% in quarter two and 94% in quarter three (October to December). In comparison, data for specialist medicines showed that the divisional average for quarter one was 96%, 86% for quarter two and 85% for quarter three.

During the inspection we observed staff washing their hands before and after patient contact in both Sky A and the medical receiving unit (MRU). However, the audit data for hand hygiene compliance was not consistent for these areas. Hand hygiene compliance for MRU in 2022 was 80% in May, 100% in August and 50% in October. Hand hygiene compliance for Sky A in 2022 was 100% in May, 83.3% in August and 65.4% in October.

The IPC nurses completed IPC clinical audits monthly and this included peripheral catheters, central lines, urinary catheter and assessing compliance against MRSA admission screening and the use of bowel charts. The divisional average for the care of elderly wards was 75% for October 2022, which was an improvement from September 2022 where it was 69%. In comparison, the divisional average for specialist medicines was 73% for October 2022.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had enough PPE and staff followed the trusts policy when supporting patients, including wearing masks, aprons, gloves and face shields where necessary. Hand sanitiser and washing facilities were available on all wards. Signage advised staff and visitors to follow infection control practices, when entering and leaving ward areas.

Medical care (including older people's care)

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff washing their hands before and after patient contact. We observed appropriate isolation notices on side room doors which were closed.

Cleaning schedules were up-to-date and demonstrated that all areas were cleaned regularly.

Patients were screened on admission for Covid (when showing symptoms or high risk/ vulnerable patients), *Influenza* (when showing symptoms), methicillin-resistant *Staphylococcus aureus* (MRSA) and methicillin-susceptible *Staphylococcus aureus* (MSSA).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All wards we visited had separate male and female bays, with separate toilet and washing facilities allocated to each bay. Entry into and out of the ward was secure with swipe access to maintain a secure environment. Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards. Wards had facilities to isolate patients and staff closed doors to treat patients who were at risk of infection.

Staff carried out daily safety checks of specialist equipment. This included safety checks of specialist equipment such as resuscitation trolleys and emergency equipment such as defibrillators. During the inspection, we saw evidence that equipment was routinely, serviced and calibrated. The equipment storerooms were well organised and clean with secure access. Fire extinguishers were stored securely and in date throughout the service.

Piped oxygen and suction equipment were available at each bed space and oxygen cylinders were stored securely.

Staff disposed of clinical waste safely. Needle sharps bins were available throughout the wards and the bins we inspected were correctly labelled and stored correctly.

Patients could reach call bells and staff responded quickly when called. Staff used the call bell system and ensured that patients had these within reach when necessary. During the inspection, we observed staff answer all call bells promptly and patients' needs were responded to. Patients we spoke with also told us staff responded to call bells promptly.

We requested results from the call bell audit with relevant action plans. We were told that the current process was to monitor one ward/unit per week and where performance was not in line with the required standards, prompt feedback was provided to the nursing leadership team and a focussed continuous improvement was actioned. Data showed that 100% compliance was achieved in Harvest A, Harvest B, Sky A and Clementine B. Sahara B achieved 78.5% and medical receiving unit achieved 60%. However, the data did not specify the date for when the audit was completed.

The service had suitable facilities to meet the needs of patients' families. The service had enough suitable equipment to help them to safely care for patients and staff we spoke with did not report any shortages of equipment. Although, therapy staff told us that their equipment was stored in the basement which meant a lot of time was spent moving the equipment to the right floor, this had been escalated to the senior team who were exploring storage options.

Some staff told us that there was limited office space available in some areas to have private conversations with staff when needed.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. We checked random patient records and saw that appropriate escalation had taken place when required. We reviewed the NEWS2 audit results for the last 12 months for both specialist medicines and geriatrics and frailty. We found that both divisions did not consistently meet the trust target of 95%. However, the trust submitted action plans for both departments to address the inconsistent compliance. The timeframe for the action plan was between November 2022 and January 2023.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Nursing and medical staff we spoke with were able to describe the signs and what treatment should be initiated in line with national and local guidance. This included awareness of the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients. The service had a sepsis trolley to support patient care.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly. The service used a seven-day booklet to capture the mandatory patient assessments, planning and evaluation. This included a range of risk assessments such as falls, nutrition, skin, venous thromboembolism (VTE), continence, cognitive, and the Braden Scale (used to predict pressure sore risk). During the inspection, we checked random patient records and found that risk assessments had been completed.

We requested VTE audit performance for the service and were provided with VTE compliance data for two areas. For October 2022, HASU achieved 80% compliance and Clementine A achieved 100%. The trust provided a copy of the action plan on how to improve compliance in HASU.

We reviewed the pressure sores audit for October 2022 and results showed that there were three category 2 pressure sores in specialist medicine and no pressure sores reported in geriatrics and frailty division. The Trust provided the pressure ulcer reduction annual workplan (from April 2022 to March 2023). The workplan listed the actions under five priorities and most of the actions were either rated amber (in progress) or green (achieved). We reviewed the workplan and found that each action listed had details of action needed, lead officer, timescale, intended outcome, progress, details of how success and impact will be measured, KPI and RAG rating.

Staff shared key information to keep patients safe when handing over their care to others. We observed a board meeting on Sky A and saw there were comprehensive discussions for each patient's treatment plan and assessments. The meeting was nurse led and well attended by nursing and medical staff, therapies and doctor's assistants.

Shift changes and handovers included all the necessary key information to keep patients safe. We observed a nursing handover where staff discussed patients in detail including information on patient observations, medications, status overnight/ any deterioration and family contact.

During the inspection, when visiting the Queens Frailty Unit, we observed staff attend a cardiac arrest and saw that staff had acted appropriately which included notifying family members of the event.

Medical care (including older people's care)

The coronary care unit (CCU) had a central monitoring system at the reception desk which alarmed to alert staff. Staff told us that alarms were set for individual patients and cardiac rhythms. The service referred angioplasty to a nearby NHS hospital specialising in cardiology.

The Frail Older Person's Advice Liaison Service (FOPALS) team took referrals from the emergency department and the care of the elderly wards. We reviewed the FOPALS assessment form and saw that the information collected was comprehensive and considered all relevant factors for a patient.

The service had access to a mental health team and medical staff could also access support from the psychologist.

Nurse staffing

The service ensured there were enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service ensured there were enough nursing and support staff to keep patients safe. Senior nursing leads could adjust staffing levels daily according to the needs of patients. Staff told us that staffing levels were regularly reviewed and increased where needed to keep patient care safe by using bank and agency staff to fill gaps. Nursing staff that we spoke with were very happy despite the challenging environment that they worked in.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a safer staffing tool to monitor staffing levels and ensured that staff were delegated appropriately across the service. Some staff told us that they were often deployed to other areas due to staffing gaps. However, the service had recently imposed a two week ban on moving staff and this had made a difference to staff morale.

The service had biweekly (Monday and Friday) meetings that reviewed staffing levels across the division and ensured that all areas had a sufficient level of staff. This included a skill mix review. There was also a monthly Divisional Review of Rostering Performance chaired by the Trust Director of Nursing for Workforce Safeguards. Future rosters were interrogated, and actions were identified to optimise staffing over the future roster periods. The senior nursing team had daily huddles to review staffing, activity, concern and key messages from overnight.

The trust provided data for nursing staff sickness, vacancy and turnover rates between November 2021 and October 2022, as monthly percentages split into three areas: geriatrics and frailty, specialist medicines and assessment and ambulatory care (Trust wide).

For specialist medicines, the yearly averages for nursing staff was 4.6% for sickness, 11.2% for vacancy and 8 % for turnover. The yearly averages for nursing support staff was 8.9% for sickness, 9.8% for vacancy and 13.1% for turnover.

For geriatrics and frailty, the yearly averages for nursing staff was 6.4% for sickness, 19.6% for vacancy and 11.4% for turnover. The yearly averages for nursing support staff was 6.9% for sickness, 18.9% for vacancy and 9.4% for turnover.

For assessment and ambulatory care, we were provided with trust wide data as the data could not be reliably split by site due to cost centres not being specific. The yearly averages for nursing staff was 6.4% for sickness, 30.1% for vacancy and 8.9% for turnover. The yearly averages for nursing support staff was 11.2% for sickness, 7.9% for vacancy and 9.8% for turnover.

Medical care (including older people's care)

Divisional leads told us that recruitment was always ongoing and nurse staffing remained on the risk register. The service was in the process of recruiting international nurses which took time. However, retention was a challenge as staff were offered development opportunities and staff often chose to work in another division as this was less challenging than the care of elderly wards (both physically and mentally).

Managers were able to request bank and agency staff where needed. Although matrons told us that requesting bank and agency staff was not an issue, the requests had to adhere to the relevant pay framework. Although divisional leads told us the trust had collaborated with a nearby NHS Trust which meant the service could use bank partners, there were still instances where some shifts were not filled as the Trust could not offer inner London waiting allowance.

We requested data for bank and agency usage for nursing staff. The trust presented the data as the number of bank and agency shifts by month, for each division and split the data into qualified nurses and unqualified nursing. The time period for the data was between November 2021 and October 2022. Both geriatrics and specialist medicines used bank and agency staff with the most usage in the specialist medicines. For geriatrics, 26% of qualified nurses shifts were unfilled in comparison to 17.8% for unqualified nursing staff. For specialist medicines, 22% of shifts for both qualified nurses and unqualified nursing staff were unfilled.

Managers made sure all staff including bank and agency had a full induction and understood the service. We spoke with new starters who told us that their induction was detailed and that they received support from the team. Senior leads told us that inductions included a two-week supernumerary phase (after the trust induction) and new starters received a welcome induction pack.

The flow lead for geriatrics had a team of one flow nurse and five discharge coordinators. The service had plans to recruit additional discharge coordinators to fill the gaps.

Medical staffing

Although the service had consultant vacancies, the service ensured there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Although the service had enough medical staff to keep patients safe, we found staffing levels were stretched following the recent departure of locum consultants. We raised this with the Chief Medical Officer who confirmed that the service had lost locum consultants after the agency pay was brought in line with national guidance.

Senior leads told us the geriatric and frailty division had seven consultant vacancies. Between August and October 2022, consultant vacancies by speciality were highest in the following areas: renal (45.5%), stroke services (41.2%), neurophysiology (24.5%), respiratory (18.2%), cardiology (16.7%) and dermatology (17.1%). However, it wasn't clear from the data if this was trust wide or site specific information. Although managers could request locums when needed, divisional leads told us that the reduction in agency pay and absence of London waiting allowance, hindered the fill rate of shifts and had caused locums to leave the division.

The trust provided the bank and agency usage for medical staffing between November 2021 and October 2022. The data was presented as monthly figures split into three areas: geriatrics and frailty, specialist medicines and assessment and ambulatory care. All three areas used bank and agency staff with the most usage in the geriatric's division. Data showed that 21% of shifts were unfilled in geriatric and specialist medicines in comparison to 33% in assessment and ambulatory care.

Medical care (including older people's care)

The trust provided data for medical staff sickness, vacancy and turnover rates between November 2021 and October 2022, as monthly percentages split. The data was not site specific and the trust target was not included. The yearly averages for medical staffing (career grades) was 1.5% for sickness, 23.8% for vacancy and 2.9% for turnover. The yearly averages for medical staffing (training grades) was 4.6% for sickness and 17.8% for vacancy.

Senior leads told us medical staffing was on the risk register. Staff told us that consultant vacancies had led to delays in completed electronic discharge summaries, delays in specialist referrals on wards and missed training opportunities for junior doctors due to the workload pressures. However, junior doctors also told us that they could always access support from a consultant when needed.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We reviewed the rota for last six weeks and although we found that areas had been sufficiently staffed, staffing levels were thin which didn't leave much room, for example, if there was sickness.

Divisional leads told us that they were in the process of improving the work plans for geriatricians to make them more appealing prior to advertising for the vacant posts. The Trust was also reviewing the consultant model by arranging peer reviews with nearby NHS hospitals and having regular engagement meetings with the medical staffing in the service. Divisional leads told us that during the pandemic, registrars had stepped up to consultant level but could not independently look after a ward without a Certificate of Completion of Training (CCT) consultant. Despite the work pressures, medical staff we spoke with remained passionate about their work and still enjoyed coming to work.

Managers made sure locums had a full induction to the service before they started work. Divisional leads told us that inductions for locum consultants was managed by the service manager.

The service always had a consultant on call during evenings and weekends. Weekend cover for the care of elderly wards consisted of a junior doctor and senior house officer (SHO) for wards with access to one consultant (who covered all four wards). Divisional leads told us this was appropriate staffing to keep patients safe as the Queens Frailty Unit (QFU) had at least two if not three geriatricians who could support the on-call consultant if needed. The hyperacute stroke unit (HASU) had dedicated on call registrars for stroke or a neurologist.

Senior leads told us that three out of four care of elderly wards (Mandarin A, Mandarin B and Clementine A) had consultant cover whilst Clementine B did not due to the recent departure of a consultant. As a result, the service had recently changed Clementine B to a step-down ward for medically fit patients. Although Clementine B was staffed with a registrar, divisional leads told us that staffing was appropriate as a medically fit ward did not require the same input as an acute ward. Senior leads and nursing staff told us that consultants attended ward rounds twice a week on Clementine B. However the service had consultant cover in QFU, medical receiving unit, Sky A and the coronary care unit.

Is the service effective?

Inspected but not rated ●

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Medical care (including older people's care)

The service participated in relevant national clinical audits. Examples included, but were not limited to, the National Early Inflammatory Arthritis Audit (NEIAA), Sentinel Stroke National Audit Programme (SSNAP) and the National Lung Cancer audit. Performance in national outcome audits were variable. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required. For example, the National Lung Cancer audit showed that from the five metrics, the trust was within expected range for three metrics and showed good practice for one metric. However, the Trust achieved 71.8% for one metric (crude proportion of patients seen by a Cancer Nurse Specialist). Although this did not meet the national minimum standard of 90% and the national aggregate was 73.4%, the trust had an action plan to improve patient outcomes which we reviewed.

Managers and staff used the results to improve patients' outcomes. Staff were aware of audit results and were able to reflect on things that had gone well and that needed to be improved. Divisional leads told us that specialties discussed audit results and actions at multidisciplinary meetings. Staff we spoke with were knowledgeable of relevant national audits and were able to talk about how their work contributed towards a culture of improvement.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Trust data was provided for delayed discharges between May 2022 and October 2022 with the reasons for delay. Although there were numerous reasons for delay, the top four reasons included awaiting place for nursing or residential home 13.5%, awaiting rehabilitation bed 9%, awaiting restart/increase in long term package of care 7.7% and family delay 7%.

Data for number of patients discharged out of hours (between 8pm and 8am) showed that between January 2022 and October 2022, there were 10083 discharges at the Queen's Hospital site.

The waiting time (in hours) for QFU from decision to admit (DTA) to admission varied. Data showed that between May 2022 and September 2022, waiting time ranged between one and eight. We requested the waiting times for CCU and we were provided with the flow metrics for CCU between June and October 2022. Although the metrics covered stranded patients and discharges, it wasn't possible to deduce the waiting times from the data.

Between October 2021 and October 2022, the average length of stay (in days) for the care of elderly wards was 13 whilst QFU was 2.1 days.

We requested the readmission rates for infection and did not receive this as the Infection Prevention and Control (IPC) team did not audit this. We were told that the trust monitored and followed up infectious patients that had been readmitted as they would have a red flag on the electronic system. The trust had plans to embed the new IPC electronic system from 30 November and told us that the system would be able to monitor and report readmission rates for infection.

Patients seen in the coronary care unit were referred for cardiac rehabilitation automatically which was led by the rehabilitation team. The cardiac rehabilitation team provided a multidisciplinary eight-week programme to empower patients with knowledge and understanding to maintain positive health and wellbeing after an admission to the cardiac care unit. Between January 2022 and October 2022, the Trust's cardiac rehabilitation data showed that there were 1016 referrals of which 59 were not in scope and 215 were declined. The cardiac rehabilitation programme (CRP) was started for 699 patients and completed for 689 patients.

Medical care (including older people's care)

Staff told us the service completed clinical audits such as hand hygiene using 'Medical (or Clinical) E-Governance' (MEG) audit tool. MEG is a cloud-based software which connects all the key components of clinical governance and quality management in one place.

The service used seven-day nursing bundles to improve patient outcomes. Examples included, but were not limited to, falls, pressures sores and catheter risk assessments.

The service organised mortality reviews for complex patients. Senior leads told us this was led centrally and included all the relevant specialities. The service had an associate medical director (AMD) who led on the learning reviews from deaths.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The Care of Elderly wards had nursing handovers at 7.30am followed by two multidisciplinary ward rounds at 9am and 2pm whilst the Queens Frailty Unit (QFU) had a daily multidisciplinary board rounds at 12 noon. We observed a board round on Clementine A and Mandarin A which was well attended by a multidisciplinary team. This included nurses, nursing associates, doctors' assistants, physiotherapists, doctors, occupational therapists, senior nursing staff and discharge coordinators. Discussion included patients' diagnosis, treatment plans and diagnostic investigations, social placements, concerns and any discharge planning. All staff were fully engaged and participated in the board round. Medical staff we spoke with praised the nursing staff.

Patients had their care pathway reviewed by relevant consultants. Patients on the hyperacute stroke unit would receive a face to face consultant review within 12 hours. Senior nursing leads told us it was easy to make referrals to specialist teams for support. Staff told us that MDT meetings would be arranged as needed to discuss complex patients and all the relevant departments attended.

We reviewed various MDT meeting minutes for hospital flow and found that each meeting had an attendance log and action log. The action log included information on actions needed, named owner, target completion date, status and comments.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with during our inspection were aware of the mental health liaison teams and divisional leads told us they were working closely with the mental health provider focusing on the priorities for winter.

Although the service had a dedicated social worker who attended board rounds virtually, staff told us that social workers used to have presence on the wards, but this had stopped since the pandemic. However, when we raised this with senior leads, we were told that social workers had started to come on site recently.

Seven-day services

Most of the key services were available seven days a week to support timely patient care.

Divisional leads told us that there was a medical on call team including senior medical staff, which was available on weekdays, and on call out of hours and weekends. The service had duty matrons shifts on weekends across the hospital and these shifts came around every two months. Similarly ward managers also had on call shifts every two months.

Medical care (including older people's care)

The dietetic service was available Monday to Friday 9am to 5pm with no weekend cover. Staff told us they had good access to the Speech and language therapists (SLT). Staff reported good access to the tissue viability nurses (TVN) and told us that the TVN report was included in discharge summaries and could be shared with care homes if needed.

The occupational therapists (OT) were available Monday to Friday 9am to 5pm with no cover in the evenings and weekend. Staff told us this was due to OT vacancies which affected the trust and was an issue nationally. There was currently one OT for the four care of elderly wards. However, staff told us that if an OT was required on weekends, they could contact the senior lead or the OTs from the emergency department who could help the wards if needed.

Staff could call for support from doctors and other disciplines, including physiotherapy, diagnostic tests, imaging, palliative care and infection prevention and control team, seven days a week. Staff told us that urgent imaging could be arranged at night and weekends if needed. Staff told us that they could easily access and manage test results and investigations results using the electronic system.

The service had a dementia and delirium team which was available Monday to Friday. Staff told us that they could access the medical consultant out of hours if needed. Although the learning disability (LD) lead was only available Monday to Friday, senior leads told us that all matrons had completed LD Level 3 training so that they could provide out of hours cover on evenings and weekends. Patients also had LD hospital passports.

The mental health liaison service was provided by a community mental health provider. The service included emergency (one-hour response) assessments and routine (24hour) reviews. Staff were able to make referrals easily and contact the team for emergency/ urgent assessments.

The trust offered psychological support for their staff which was managed by occupational health. The service provided both assessment and treatment for staff experiencing complex trauma.

The Frail Older Person's Advice Liaison Service (FOPALS) team provided a seven-day service; Monday to Saturday 8am to 8pm and Sunday 8am to 4pm.

The pharmacy team were available Monday to Friday with evening cover managed by an on call pharmacist and a site manager (for access to emergency medicines). Ward staff told us that they would like to have a dedicated pharmacist but this wasn't possible due to vacancies in the pharmacy workforce.

The critical care outreach team (CCOT) was available Monday to Friday 9am to 5pm. Staff were able to bleep the clinical site manager out of hours and on the weekend who would then escalate appropriately to the outreach team.

Is the service caring?

Inspected but not rated ●

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection, in all the areas we visited, we witnessed staff interacting positively with patients and answered patients' questions.

Staff followed policy to keep patient care and treatment confidential. Staff used curtains or privacy screens where needed to maintain patients' privacy and dignity. We saw that when a patient was being examined, the curtains were drawn around the patient to maintain privacy and the dignity of the patient.

We observed staff interact with patients living with dementia in a calm and caring manner. Senior leads told us that volunteers visited patients living with dementia and read the newspaper to them.

Patients told us that although staff were rushed off their feet, staff always had time to be patient and helpful. Patients said staff treated them well and were very caring.

Staff displayed thank you cards for the public to view. Comments in these cards included "thank you for your compassion, kindness and hard work", "you are all so kind and caring", "you are awesome" and "I haven't felt this loved by strangers ever".

Friends and Family Test (FFT) results for geriatrics and frailty showed that from 1417 responses, 93.4% were positive. Results for acute medicine showed that from 860 responses, 93.1% were positive and for specialist medicines, 3136 responses were received of which 92.1% were positive.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us that staff kept them informed of their treatment plans, medication changes and staff change for both nurses and doctors.

Discharge coordinators liaised with families to inform them when patients were due to arrive home. The Trust had a leaflet which contained discharge information for patients. This included information on discharge planning, what happens before discharge, what happens on the discharge day and a to-do checklist. The leaflet also included contact information for the ward where the patient was discharged from and details of either home carer package or assistance from social services if they had been arranged. Staff told us that either nursing or medical staff completed follow up calls with the patient post discharge. Patients received a contact list for both physiotherapy and occupational therapists where necessary.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff said they had access to communication aids, and these were used to help explain care to patients who may have difficulties with expressing how they were feeling or were living with dementia.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service.

During the frailty unit board round, we observed good advocacy for patients; for example, spiritual needs such as referral to a chaplain was discussed.

Medical care (including older people's care)

The service used blue wrist bands for identification of patients living with dementia. The service used the Butterfly scheme and offered Reminiscence Interactive Therapy and Activities (RITA) on wards to support patients. RITA is a tool that helps patients recall memories, patients relax in the hospital environment and encourage conversation and interaction between patients, their family and staff.

Is the service responsive?

Inspected but not rated ●

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Patients received comprehensive geriatrics assessments by a specialist multidisciplinary team (MDT) on arrival in the Queens Frailty Unit (QFU) alongside a holistic frailty management plan from the outset. This system prevented duplication of assessments by multiple specialities as there was a standardised MDT screening process.

Facilities and premises were appropriate for the services being delivered. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw evidence of single sex bays, toilets and shower facilities on most wards.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a variety of specialisms in addition to specialist link nurses who were available to offer advice and support to staff and patients. Examples of link nurses included, but were not limited to, pain, dementia and delirium, mental health and infection prevention and control (IPC).

The service had a Frail Older Person's Advice Liaison Service (FOPALS) team who helped streamline patient discharge by arranging relevant follow up tests and assessments for the patient. This meant patients did not have to spend longer time in hospital than necessary. The FOPALS team also worked closely with the emergency department to ensure any social services referrals were made at the outset.

Staff had access to translation services where needed.

Access and flow

Although people could access the service and received the right care, wider system issues impacted the hospital's flow and led to delays in discharge. The service continued to work at capacity to reduce waiting times for referral to treatment times.

Medical care (including older people's care)

Managers monitored waiting times; however, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. The trust was operating at capacity. Divisional leads told us that although the population the trust served had increased and continued to do so, the hospital's capacity remained the same. The trust was working on continuously improving flow with projects such as Operation Snowball, FOPALS team, and Red2Green Team but the sheer patient volume and complexity was challenging.

In May 2021 the trust opened the Queen's Frailty Unit (QFU) for patients aged over 75. The unit was open 24 hours with 30 beds to provide patients a holistic frailty management plan from the outset. Patients would bypass the traditional Emergency Department (ED) route in an effort to provide the specialist care they need and reduce wait times. The QFU worked closely with ED in the Rapid Assessment and First Treatment (RAFT) area and used a patient transfer criteria for example, no stroke patients would be taken to QFU. Senior leads told us that one side room was used as a discharge lounge for patients awaiting medications ahead of discharge but were confused. This meant it was not appropriate to transfer them to the hospital's discharge lounge but as a result, there could be up to 36 patients in QFU.

The medical receiving unit (MRU) received direct admissions from ED and Emergency Same Day Emergency Care (ESDEC). Staff told us that patients could stay up to three days in MRU before getting transferred to wards.

The service had daily meetings such as huddles and bed meetings where access and flow were discussed at a ward level. Bed meetings also included discussions on medical outliers. Ward managers and discharge coordinators worked to move patients to discharge once care had been coordinated with community support services.

Managers and staff started planning each patient's discharge as early as possible. The Red2Green team was comprised of discharge coordinators who focussed on discharge pathways out of the hospital with community partners. Staff told us that there was a dedicated discharge coordinator for the homeless. The team worked closely with the wards and attended board rounds to reduce any delays to patients being able to leave the hospital. The team had a daily conference call with system partners to speed up patient discharge. We attended the daily call and found that comprehensive discussions took place for each ward by site. On inspection, we observed the presence of discharge coordinators on the care of elderly wards.

Staff and senior leads told us that system issues such as obtaining nursing home placements and social care packages (especially for out of area patients) contributed to delays in discharge. Staff told us that nursing homes did not accept new patients on a Friday after 4pm as general practitioners (GPs) would not be available on the weekends. This led to delays in discharges. Staff told us that care home staff did not answer phones and when this occurred, this was escalated to the general manager. Staff told us that the patient transport service had improved and was no longer an issue for discharges.

The trust had policies for managing stranded patients/ out of area patients aligned to different boroughs. The service reviewed stranded patients on a weekly basis with a second weekly review as part of national reporting. We requested data for the percentage of patients out of area for the last 12 months. Data for Queens Hospital showed that 365 adult patients (excluding maternity) were medically fit and had exceeded seven days for length of stay. Of these, 70 patients (19%) were out of area. Data showed that 19 patients from the 70 (27%) were medically fit but stranded as they were out of area patients.

The service had recently started Operation Snowball six weeks ago as an initiative to improve patient flow out of ED. Patients from ED were transferred to either the QFU or the Care of Elderly wards (Mandarin A, Mandarin B and Clementine A) periodically over the day. The flow nurse would have oversight of the planned discharges on the care of elderly wards and would liaise with ED when to transfer patients. Although nursing staff told us that patients were

Medical care (including older people's care)

transferred using paper-based handovers, junior doctors told us they received no communication from ED regarding the patient. They were expected to check the electronic records (Careflow) in order to understand what assessments had taken place in ED. This increased work pressure as the wards were already challenged with 30 patients on each ward. We raised this with senior leads who told us that only stable patients would be transferred to the wards. Similarly, the QFU had a patient criteria for transferring patients from ED into the unit. Senior leads told us that this system worked better as previously patients were brought to QFU directly from ambulances. Although senior leads told us that staff could pause the transfer of patients during operation snowball (referred to as pit stops) if needed, it wasn't clear if all staff were aware of this. Staff told us that although the snowball initiative was positive, it had increased pressure on staff due to high patient numbers in bays which was further exacerbated by the complexity and acuity of patients.

Although staff told us that the service had recently changed Clementine B to a stepdown ward following the departure of a consultant, senior leads told us that the stepdown ward ensured all medically fit patients who were ready for discharge were in one area. Senior leads told us that patients were not transferred to Clementine B as part of Operation Snowball. Staff told us that discharges were nurse-led which meant patients were discharged directly from Clementine B.

However, we found that the discharge lounge which had recently been relocated to the ground floor was underutilised. Staff told us that the discharge lounge criteria has been amended and only included patients who were fit to sit on chairs with appropriate care plans, completed electronic discharge summaries (EDS) with to take away (TTA) medicines, confirmed care home placements and ready for discharge on the same day. Although the discharge lounge was open seven days a week from 8am to 8.30pm and co-located with the patient transport service, staff told us usage had reduced following the recent introduction of the new criteria (one week prior to the inspection). Staff from the discharge lounge told us they proactively liaised with wards to see if any medically fit patients could be sent down to the discharge lounge. Staff told us that the discharge lounge was not included as part of operation snowball initiative.

The NHS Constitution states that 'no-one should expect to wait more than 18 weeks from the time they are referred to the start of their consultant-led treatment, unless it is clinically appropriate to do so or they choose to wait longer'. The geriatrics and frailty division had 189 patients awaiting appointments from which 87% had had appointments booked and the remainder, were in the process of being booked in. The division had 8.99% of patients breaching the 18-week referral to treatment (RTT) pathway. No patients were waiting beyond 52 weeks for this division.

However, data showed that the neurosurgery waiting list had increased due to reduced theatre capacity following the pandemic. Neurosurgery currently had a patient tracking list of 4000 patients with 150 awaiting surgery and 2700 awaiting a first appointment. The current conversion for surgery was 11% which meant that a further 297 were expected to be added to the surgery waiting list bringing the total to 447. The trust had a recovery plan which included putting in place numerous mitigating actions to maximise efficiency and increase capacity between May and September 2022. These included but were not limited to, creating 42% new patient slots in comparison to 2019/2020, increased clinic slots, increased follow up telephone clinics and putting on additional weekend clinics.

Specialist referrals were completed online. QFU staff told us once referrals were made, specialist reviews took place within 24 hours. However, staff on the wards were starting to see delays of up to four days until a specialist review was completed due to the lack of medical staffing in some specialisms such as respiratory and cardiology.

Sky A was a 24 bedded medical short stay ward which aimed to reduce pressures on ED and patient flow. Data showed that Sky A achieved 67.2% compliance for the 72-hour target key performance indicator (KPI) between May and November 2022.

Medical care (including older people's care)

Therapy staff told us that getting equipment to a patient's home was a challenge at times as part of discharge. Although the service used taxis to deliver equipment to the patients' home, there were occasions when no one was at home to receive the items despite earlier correspondence.

The hyperacute stroke unit (HASU) on Harvest A provided a thrombectomy service either 8am to 8pm or 24 hours depending on the rota. If the service finished at 8pm, a nearby NHS hospital provided out of hours cover. The team received a call once the patient was in resuscitation and acted quickly to obtain clinical histories from the paramedics and family members. The team ensured appropriate scans, assessments and specialist referrals were completed and staff told us they had access to the imaging department. The therapy team organised a six-week plan as part of rehabilitation post stroke. The HASU team worked closely with the long-term rehabilitation unit (Daisy ward). Staff told us that general practitioners (GPs) were able to refer transient ischaemic attack (TIA) patients (mini stroke) for magnetic resonance imaging (MRI). HASU had 24-hour access to most diagnostic imaging, albeit MRI was at times harder to access.

Within HASU, there was a dedicated space for a stroke ambulatory unit which was open Monday to Friday 9am to 5pm. Patients seen in ED would have started treatment while investigations continue and would be referred to HASU. General practitioners (GP) were able to refer patients and the online referral form included symptoms, risk factors and treatment options. Once a referral had been made by the GP, the patient would be offered an appointment to be seen within two to three days. The unit reviewed four to eight patients daily and was staffed by a stroke consultant and stroke specialist nurse. The team arranged follow ups with patients and sent the reports to the GP electronically (or by post). The unit had a process for patients who required admission and we were told that although bed spaces could be arranged early, this did not occur often. Staff told us that the process would be easier if the service was digital like ED. The unit was due to go digital during the week of the inspection but due to a glitch, this had been pushed back to mid-November.

Is the service well-led?

Inspected but not rated ●

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had an established leadership structure for both the specialist medicines division and geriatric and frailty division. The structure included divisional directors, divisional managers and divisional director of nursing. Senior leads told us that both divisions were due to merge as part of the Trust's transformation changes by the end of March 2023.

Senior leads understood the challenges to quality and sustainability the medical care service faced and had plans in place to address them. However, some of the challenges related to the wider healthcare system. Senior leaders for the service told us that the vision for the service was to be out in the community. The service had plans to open a frailty hub which would be a one stop shop for patients and this hub was due to open in 2024.

Medical care (including older people's care)

Staff demonstrated awareness of the leadership team and described them as visible. The service leads we spoke with told us that executives were visible and approachable in the department. We observed matrons were visible on the wards and they were knowledgeable about the ward's performance and the areas of improvement. Staff told us that they were able to raise concerns as needed. Staff we spoke with showed awareness of freedom to speak up guardians should they need to raise a concern.

Most staff we spoke with told us that managers were supportive and approachable, and felt their concerns were listened to. However, we found pockets of staff that did not feel respected and told us about alleged racism in one area of the service. We raised this with senior leads who told us they were aware of these issues and were in the process of addressing them.

Although staff told us that the work pressure was fast paced, all the staff we spoke with reported a happy working culture and enjoyed coming to work. Most staff told us that they were supported to develop their skills. For example, healthcare assistants were encouraged to develop their skills by completing their nursing associate training following by registered nurse training.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. We reviewed the risk and compliance group meeting minutes between August 2022 and October 2022 and found there was consistency in the format and structure of these meetings. The meeting agenda included discussion on outstanding risks, workforce, finance, corporate risk report, policy report and central alerting system. The meetings had good attendance with representation from each division.

The divisional team described their top risks as flow, staffing and increased complexity of dementia patients. The trust served an ageing population which continued to increase alongside the challenges in the social care system. However, the trust's capacity remained unchanged.

We reviewed the Specialist Medicine Division and Geriatric and Frailty division reports for November 2022. The reports detailed a summary of risks and we found that risks were appropriately documented with named risk assessor, risk score, risk controls and action plan. We saw that risks identified on inspection were on the risk register, including medical staffing, nurse staffing and the risk of violence and aggression or abuse to nursing and medical staff from patients with dementia or a cognitive impairment.

We reviewed the quality and safety meeting minutes for the geriatrics division between July 2022 and October 2022 and found there was consistency in the format and structure of these meetings. The meeting agenda included discussion on outstanding risks, serious incidents, staff rota, updates from each area, staffing, complaints, clinical effectiveness, mortality review and patient feedback. We found the same consistency in the ward managers forum minutes.

Many patients did not have access to general practitioners during the pandemic which meant patient acuity and complexity had increased. Senior leads told us that since the pandemic, the service had seen an increase in patients presenting more confused with progressed dementia and often displayed aggressive behaviour. This meant staff had to cohort patients on the bays appropriately and obtain funding for one to one care which was a cost pressure.

Medical care (including older people's care)

Each area identified local risks through discussion at monthly quality and safety meetings where all staff could attend. During the inspection, we saw Quality and Safety Boards in all the areas that we visited which included information on incidents and learning. Senior leads told us that each area's risk were discussed at the monthly governance meetings. We reviewed the quality dashboard performance meeting minutes between November 2021 and October 2022 for specialist medicines and geriatrics and frailty. The agenda included finance, staffing levels and staffing wellness, recruitment, summary/ headlines, risks and issues and next steps. Each meeting kept an attendance log.

The senior nursing team had regular meetings with the triumvirate team. In addition, the service had weekly tracker meetings which reviewed risks, complaints and incidents for both trust's sites. Ward managers had weekly meetings across both trust's sites.

The service mitigated the staffing levels risk by using bank and agency staff and maintaining the recruitment drive. Senior leads told us that although staffing levels had improved since the last inspection, agency rates impacted the fill rate of shifts. The additional challenge to recruitment was finding staff with the right mindset to work on the care of elderly wards which had higher workloads in comparison to other areas.

The transformation team had completed a quality improvement project on nursing handovers on Mandarin A. Results included improved handover time and board round effectiveness ensuring key information was discussed to manage time. We reviewed the target progress report for the 30-day, 60-day and 90 actions and found that from the 11 metrics, 100% change was achieved for nine of them. Staff told us that the biggest impact of the project was nursing staff going home on time and patient safety with more accurate handovers.

The trust had a Local Emergency Preparedness Policy which was in date. The policy ensured the trust was prepared for emergency preparedness, business continuity management system, continuity planning especially in events of hospital lockdowns and recent examples of flooding.

King George Hospital

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Description of this hospital

King George Hospital is situated in the London Borough of Redbridge, the hospital includes an emergency department (ED), an intensive care, services for children and young people, and a recently refurbished diagnostic imaging department. Despite being the smaller of the two trust hospital sites, activity at the hospital was increasing and the trust were establishing a site-based leadership team to improve the management and oversight of the services the hospital delivered.

In December 2021, we sent the trust a letter of serious concern following a focused inspection of emergency department (ED) care at Queen's Hospital. At that time, we did not undertake an inspection to the King George Hospital site ED. Following that inspection at Queen Hospital ED, the team found significant concerns with the streaming and triage processes; the length of stay for patients within the department and subsequent overcrowding, ambulance handover times, and the delayed flow of patients from the hospital into the community. The Commission acknowledged that some of the issues the trust faced were complicated by wider challenges within the local health and social care system. The trust responded with action plans for improvement and this was followed up through reviews and engagement.

On this occasion, we extended the inspection to the emergency and medical divisions at both trust hospitals and we also inspected the well-led key question for the trust overall. Our unannounced inspection was conducted in the same week as an unannounced inspection of the urgent treatment centres (UTC) on both hospital sites. These UTCs are operated by another provider and are reported separately.

We found concerns in interfaces between the ED and the UTC, compounded by delayed admissions of patients to speciality services and social care.

Waiting times and flow through the department continued to be a significant concern. Other key aspects such as the use of incompatible computer systems, also contributed to the delays and increased the risk of error.

After the inspection, we told the trust and the UTC provider they must make improvements.

This inspection of King George Hospital also included a comprehensive inspection of diagnostic imaging.

Our findings

Summary of urgent and emergency services at King George Hospital:

- There were delays in moving patients into and through the department and on to wards. This resulted in delays in assessment and treatment for some patients. Poor hospital flow led to delays in accessing hospital beds for patients who required an admission.
- People could not always access the service when they needed it and did not always receive care promptly. Senior clinical oversight of patients was not always evidenced which increased blockages in the department and delays to treatment.
- There were medical vacancies in the emergency department (ED) and on some days, not all services operated fully due to staffing shortages. The ED did not always have enough medical staff with the right qualifications, skills, training and experience to provide the right, safe care at all times. This increased the risk of patients suffering avoidable harm. More consultants and junior doctors were required to run the department safely.
- Staff did not always take account of patients' individual needs or always make time to help patients understand their conditions. Staff did not always give patients the right types of food or enough to eat and drink, and pain relief was not always provided in a timely manner when it was required.
- Patients did not always have an assessment of their infection risk and other clinical risks in a timely manner on arrival at the department and weren't always treated according to their priority of need.
- The use of multiple IT systems for reporting patient records caused risk of the deteriorating patient not being spotted, full notes not being available to ward staff, and difficulty recording observations using the electronic application in a timely manner.

However

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients; key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity. They provided emotional support to patients, families and carers.

Summary of medical services (including older people's care) at King George Hospital:

- Services had enough staff to care for patients and keep them safe. Premises were visibly clean and well maintained. Staff managed medicine administration well. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The trust planned care to meet the needs of local people and engaged well with other health care providers and system partners to plan and manage services.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

However:

Our findings

- Medical speciality wards were not performing well in their IPC clinical audits. An improvement plan was in place to address this.
- Not all services were completing relevant risk assessments in a timely and accurate way.
- Staff did not always follow good principals of hand hygiene.
- The service did not always involve patients as partners in their treatment and discharge processes.
- Although the trust continuously worked on initiatives to improve flow with projects such as the Red2Green Team and having dedicated discharge coordinators in each medical ward, discharges were still done as Monday to Friday activity.
- The hospital's capacity has remained the same despite an increase in the number of attendances and complexity of cases being admitted to the medical wards.

Summary of diagnostic imaging at King George Hospital:

- The trust had declared a serious incident in August 2022 relating to the accuracy of their patient tracking list (PTL), where it was found that patients who should have been on the PTL awaiting an appointment for diagnostic imaging had not been. It was not clear at the time of inspection what the outcome of any clinical harm review was, either in relation to the extent of the harm or the number of people impacted.
- Managers and staff did not appear to carry out a comprehensive programme of repeated audits to monitor safety and performance in Radiology.
- On inspection we did not see evidence of emergency evacuation procedures for the radiology department. We were not assured that there were specific emergency evacuation plans for the radiology department, as well as regular scenario training for these plans.
- There was no regular dedicated process for reviewing the quality and accuracy of information in patient records including for image quality.
- Clinical guidelines and policies were kept on the intranet, however on inspection we found there was a lack of version control for policies. We found examples of policy documents on the intranet that had not been updated or reviewed, and there were examples of multiple versions of the same policy from different years.
- The service did not have information leaflets or posters consistently displayed in communal waiting areas for diagnostic imaging.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Doctors and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Our findings

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Urgent and emergency services

Inadequate ● ↓

Is the service safe?

Inadequate ● ↓

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff understood the different forms of abuse and what action to take to promote patient safety. They explained how they would report safeguarding concerns and they could access the emergency department's safeguarding lead with questions or to seek additional advice when necessary. Staff said the emergency department's safeguarding lead was supportive and approachable with any concerns staff raised. The emergency department's safeguarding lead reviewed the records for all children who attended the paediatric emergency department daily.

The clerical staff we asked knew how to raise safeguarding alerts or concerns to the various local authority multi-agency safeguarding hubs (MASH) in the area. Agency nursing staff we asked said they had been informed that they should raise any safeguarding concerns they had with the nurse in charge.

Staff followed safe procedures for children visiting the department. Paediatric patients had their own assessment area pathway within the department. All paediatric patients we saw in the area were always accompanied.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

National guidance on infection prevention and control (IPC) measures for COVID-19 had changed since our last inspection. The trust followed the latest guidance. Facemask dispensers with prominent warning signs were sited at entry points to the hospital and we saw staff and visitors wearing masks or face shields. Hand sanitising stations were placed at entry points throughout the hospital and we observed people using them.

All areas we visited were visibly clean and had suitable furnishings which were well-maintained. Furnishings, such as chairs and flooring, were wipeable and easy to clean. We did not find any dust in hard to reach places.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. The cleaning supervisor carried out quality checks three times a day and completed documentation to demonstrate this.

Staff cleaned patient equipment after each patient use. Equipment not in use was stored cleanly. Some equipment was stored in patient bed areas and was assessable to patients. There was a risk this equipment could become contaminated between patient use. Some equipment had 'I am clean' stickers with the date the item was cleaned recorded.

Urgent and emergency services

On the whole staff followed infection control principles including the use of personal protective equipment (PPE). We observed all staff except for one doctor being bare below elbows, which enabled more effective handwashing. We also observed staff wearing surgical masks at all times. Staff wore disposable gloves and disposable aprons when they were required as they were assisting patients with personal care.

Sharps bins were clean and were not overflowing. All sharps bins we observed had been set up correctly with the date from when they were first used documented on them.

There were hand washing sinks which had soap dispensers throughout the department. In areas where staff washed their hands there were posters displayed which demonstrated the correct hand washing technique.

Due to overcrowding in the department, social distancing was difficult to achieve. Many patient bed areas had no external windows to make use of natural ventilation.

The service screened patients for potentially infectious diseases on admission such as Covid-19 (when showing symptoms or high risk/ vulnerable patients), influenza (when showing symptoms), methicillin-resistant staphylococcus aureus (MRSA) and methicillin-susceptible staphylococcus aureus (MSSA).

Environment and equipment

In times of normal demand and capacity in the emergency department, the design and maintenance of facilities, premises and equipment kept people safe. However, the use of premises during times of excessive capacity pressure did not always keep patients safe.

The department consisted of a main waiting area, triage rooms, majors A and B, resuscitation area and a separate paediatric ED with self-contained waiting and bedded areas. Patients could not walk directly into the emergency department to receive treatment; they only entered the emergency department if they were referred to the service from the onsite urgent treatment centre. Patients queued at the reception desk where their details were logged for the second time and they waited to be seen by the triage nurse or healthcare assistant.

After booking in, patients saw the triage nurse or healthcare assistant and were asked more details about their condition. Due to the layout of the department, it was possible these conversations were overheard by other patients waiting.

For patients who came to the department by ambulance, they were either handed over by ambulance crews to a senior nurse from majors A or were cared for by designated ambulance paramedics in the ambulance receiving centre (ARC). The emergency department worked with the ambulance service to handover patients within the 15-minute national handover standard but rarely met this target.

Patients could reach call bells most of the time and staff responded quickly when called. However, some patients were cared for in areas where there were no call bells. For example, when capacity pressure was high some patients were asked to sit in an area within Majors B. These patients were assessed as being fit to sit in a chair while they awaited results or for ongoing observation. The area was close to the main hub and could be overseen by staff walking around in the department, but patients did not have access to call bells in the event they felt unwell. However, staff were aware of this and these patients were observed by staff who were close by.

Urgent and emergency services

There was enough suitable equipment in the emergency department to help staff safely care for patients. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department. Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with tamper evident tags. Safety checks were carried out daily.

The department had two mental health safe rooms which were used to safely care for patients who had mental health conditions, these rooms were alarmed and ligature free. However, only one was in use at the time of the inspection due to a recent leak in the ceiling. The rooms had a door which could not be locked and could be opened from the outside, this allowed staff to intervene if a patient attempted to harm themselves.

Staff disposed of clinical waste safely. Waste bins were available throughout the department. The department had clean and dirty utility rooms, which were visibly clean and well organised during the inspection.

The service had two trolleys set up with specialist items to support people living with dementia and patients with learning disabilities, including activity items; for example, colouring books and pens and twiddle mitts. The second patient experience trolley had items for use by homeless patients, including a homeless backpack which contained hygiene items and new socks. There was also sleep well packs which had an eye mask and ear plugs.

Assessing and responding to patient risk

We were not always assured there was adequate oversight and responsibility of the patients who were waiting to be seen. Some patients were not prioritised according to their clinical need or history. Staff did not always complete appropriate risk assessments. Lack of flow through the ED contributed to delays in identifying and acting upon patients at risk of deterioration.

The service had in place a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a paper version of the emergency department safety checklist in accordance with national guidance. This checklist prompted staff to complete and record, for example, vital observations, early warning scores, antibiotic compliance and pain management every hour. We reviewed 30 sets of these documents for patients waiting in the waiting room overnight to be seen within the department. We reviewed audit data from the trust relating to patient records which showed safety metrics linked to assessing and responding to risk were being recorded in a timely way. However, when we reviewed the tool the service used to record patient's risk against the patient's clinical notes, we did not find any observations had been recorded for the 30 patients at the times or frequency that had been documented and signed off by staff. When raised with the service, we were told that staff undertook a visual assessment of each patient in the waiting room and signed to say that had been completed. This was a risk because staff may not identify deteriorating patients in a timely manner to avoid harm.

In an effort to release ambulance crews, a pilot for two weeks was underway during the inspection which had established an ambulance receiving centre (ARC). The purpose of the ARC was to allow ambulances to offload patients prior to the patient proceeding through the main ED. The ARC was a five bedded enclosed area created collaboratively with the ambulance service; it was staffed by ambulance crews allocated on the basis of two paramedics for the five patients. The ARC allowed the release of vehicles back into the community.

When patients were referred to the ED from the UTC, patients were booked in for a second time at the reception desk and asked to wait until they were called into a triage assessment room. Nursing and healthcare assistant staff triaged patients from the waiting room. This meant there was a risk of patients being in the waiting room without having their physical observations taken. As demonstrated above, we saw limited evidence of effective staff walk rounds of the area or comfort rounds for patients during our inspection.

Urgent and emergency services

Walk in patients arriving from the UTC, were not always assessed or given treatment in a timely manner. Standards set by the Royal College of Emergency Medicine (RCEM) state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. From January 2022 to September 2022, less than half of patients arriving at the ED from the UTC were triaged within 15 minutes,

Each patient within the department was entered onto an electronic board which was reviewed by the nurse in charge, this board displayed patients NEWS scores, when they had last been reviewed and any risks which had been highlighted. We found that NEWS scores weren't always easily visible on the board and not always up to date in line with patient notes.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission; these included sepsis, falls and the Waterlow risk assessment. Staff knew how to recognise patients who were at risk of stroke or sepsis and knew the correct pathway to follow.

Care and treatment was not always provided in accordance with national clinical guidelines. We reviewed 10 sets of patient notes and found the care and treatment provided to patients presenting with specific symptoms such as chest pain was not always in line with national clinical guidelines. We found that a patient had not received an echocardiograph (ECG) for over four hours after presenting to the ED following having already waited 4 hours at the UTC. This patient had not received an ECG within the hospital for eight hours after presenting with severe chest pain and history of myocardial infarct.

The emergency department had seen an increase in people attending with mental health needs during and post the COVID-19 pandemic. We found delays in transferring patients with mental health needs was having a significant impact on the capacity of the ED to treat patients in a timely and effective way. At times during our inspection there were up to eight patients who were suffering from mental ill health in the department at any one time. The service had 24-hour access to mental health liaison and specialist mental health support.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The department had two specially designed rooms which could be used to safely care for and observe patients with mental health concerns. However, at the time of the inspection one room was not in use due to a recent leak.

Staff did not always share key information to keep patients safe when care was handed over to

other departments. We found that due to the multiple IT systems being used within the department, that ED medical documentation was separate to nursing and specialty documentation, which posed the risk that important information could be lost or not included within patient files. We also found that medication charts were in two separate sheets within the patient paper notes, which meant there was a risk of duplication of medications.

From the handovers we observed we found that handovers included all necessary key information to keep patients safe. However, for some patients who were in the department for more than 24 hours, this meant repeated handovers between several different ED teams. Some patients were handed over three times to both nursing and medical staff. There was a risk key information about a patient's care and treatment may get missed or delayed.

Urgent and emergency services

Staffing

The service had enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, the service did not always have enough medical staff to keep patients safe.

Assurance of safe staffing in the ED was assessed using a safer staffing tool, professional judgement, activity and flow data, and acuity and dependency where applicable. Individual patient acuity and overall department patient need, and status were considered three times a day at leadership team huddles called pit stops.

When nursing staffing was not meeting planned levels, the trust would use bank or agency nurses. All bank and agency staff we spoke with had completed an induction and were familiar with the department.

The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings. This meant the department was always staffed with two registered children's nurses. Data showed staff were up to date with appropriate paediatric intermediate life support.

The service did not always have enough medical staff to keep patients safe. The number of medical staff did not always match the planned numbers. There were significant gaps in consultant cover in the paediatric ED, especially at weekends. There were some weeks in September and October 2022 when there was no consultant cover all weekend. The data provided by the trust post inspection showed that for the two months preceding the inspection, September and October 2022, out of 122 shifts there were 42 shifts that were uncovered and these uncovered shifts were predominantly on weekend days, with four out of nine weekends not having any onsite consultant cover whatsoever. The vast majority of the remaining 122 shifts, 63 shifts were either covered by bank, agency or locum consultants. Only 23 shifts during the two-month period were covered by a substantive consultant.

There were also significant gaps in cover for junior doctors. We reviewed data which showed from August to November 2022, there were a significant number of shifts that were either vacant or filled with bank or agency staff. In August 2022, out of 749 shifts, 135 were not covered and 371 were covered by bank or agency staff.

Junior doctors told us there was regular teaching and supervision and that they felt well supported whilst working in the department. Some doctors we spoke with said they would not recommend working in the King George Hospital ED because of practical issues with the referral pathways and lack of access to specialities

Managers made sure agency staff had a full induction to the service before they started work. Managers told us that the majority of staff that filled bank and agency shifts were familiar with the department.

Records

Staff did not always keep detailed records of patients' care and treatment. Records had missing items and multiple IT systems caused concern of missed information.

The service used a mix of paper and electronic patient records. This was an area of concern because ED clerking was not available for admitted patients because the records were not photocopied and added to the paper records. This was a risk because the receiving ward did not receive full patients notes.

The use of an app on electronic tablets for the recording of patient observations was raised a concern by multiple staff we spoke with. The electronic tablets frequently lost charge and took a few hours to recharge during which time patient observations could not be recorded. The risk was they were not then retrospectively added to the patient records.

Urgent and emergency services

We reviewed ten sets of patient records and we did not find any evidence of senior clinical review having taken place in any of the records. One patient in resus had not had any A to E assessments undertaken (airway, breathing, circulation, disability and exposure). One patient who was living with Parkinsons disease had not had this flagged in their notes with a green sticker and had not been receiving their time critical medication in a timely manner. One set of notes showed a patient had low potassium level which had not had any treatment for seven hours.

Patient records were stored in trolleys which were located around the central nursing hubs. Whilst the notes trolley lids were frequently closed, we found them to always be unlocked. This was a risk because notes could be removed or viewed by unauthorised persons.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Medicine management issues within the ED were being caused and exacerbated by issues with flow resulting in the long length of stay for high numbers of patients within an inappropriate setting. This resulted in increased risks around missed doses of medication and medicines security. For example, one patient had been in the ED for over 80 hours with a decision to admit but no bed available in the wider hospital. This patient had run out of their medication which they had brought in with them, but they relayed to us how difficult it had been to get an ED doctor to prescribe the medication they needed. They stated the doctor had prescribed the medication in the end but had only prescribe one dose so they feared they would have to start the process again the following morning if they were still waiting for a bed.

Where patients attended the ED with their own medication, this was not stored securely by the trust and instead remained the responsibility of the patient.

Is the service effective?

Inspected but not rated ●

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health. The service did not always make adjustments for patients' religious, cultural and other nutritional needs.

Staff didn't always consider patient comfort or offered food, fluids and pain relief when they needed it. We spoke with a patient who was vegan and had been in the department for over 80 hours but had had to eat yoghurt and porridge with cow's milk in it because staff were unable to get vegan alternatives for them. Another patient had to request a family member to bring them in food from home because they were hungry. Pain relief was not always given in a timely manner.

Is the service caring?

Inspected but not rated ●

Urgent and emergency services

Compassionate care

Staff treated patients with compassion and kindness and respected their privacy and dignity. However, they could not always take account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients with compassion and feedback from patients confirmed that staff treated them with kindness.

We spoke with patients who told us that the staff were working very hard but they did not have enough time to clearly communicate the plan of care and so they were left wondering what was happening.

Staff showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Is the service responsive?

Inadequate ● ↓

Access and flow

The trust faced significant challenges with access and flow which meant that they could not always ensure people were able to access the emergency department when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers and staff worked hard to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was achieved. The emergency department collected data and monitored how many people were in the department, how long they had been in the department and how many patients had arrived by ambulances or were waiting to be handed over by ambulance staff. The data was discussed at bed meetings during the day. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national targets for ED care were not met.

The trust had struggled for many years to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours. We reviewed the data relating to this and found that the average time spend in the ED from January 2022 up to and including September 2022 ranged from eight hours and 30 minutes in May 2022 to 11 hours in September 2022.

The lack of medical doctors in ED led to many patients waiting in the ED longer than necessary resulting in delays in decisions about their care, and delays in commencing specialist treatment.

There were insufficient beds available in the rest of the hospital to accommodate all the patients in ED who needed admitting. Throughout most of our inspection, there were up to 45 patients waiting for a bed in the ED. ED doctors were frustrated by a lack of progress in addressing the trust flow issues and poor hospital flow was identified as having a major impact on the care of their patients.

Urgent and emergency services

There were regular meetings held each day, with representation from across the trust. Escalation triggers regarding bed availability and demands on services, were discussed and assessed in accordance with the risk. The information was provided to staff following these meetings and prompted action to try to free up bed capacity across inpatient areas.

Managers and staff did not always plan each patient's discharge as early as possible. We found that discharge planning within the wider hospital operated like a five day service. The service started the week on Monday morning with many patients waiting in the ED with a decision to admit. On the first day of the inspection, a Monday, there were 46 patients with a decision to admit waiting in the ED for an inpatient hospital bed. Ward staff worked all week to discharge patients and move patients out of the ED for the number of discharges to almost cease over the weekend with sometimes as few as one patient being discharged from the wider hospital on each day over the weekend. Then the process started again on Monday.

The two bed management meetings we observed during our inspection focussed on hospital bed occupancy, number of empty beds and the number of patients with a decision to admit in the ED, and it was evident that there were not enough beds available in the hospital.

We did not see evidence that service managers and trust executives discussed the monitoring capacity and demand pressures. We did not see evidence of discussions between managers and the trust's executive team to identify how many additional beds were needed for patients for the day or night. When demand was in excess of bed spaces, patients remained in the ED overnight and were moved to inpatient beds as and when a bed became available which could at times be up to four days.

Current waiting times for triage and access to a clinician were clearly displayed in the emergency department waiting room on a white board. At 8am on the morning of the second day of our inspection the waiting time to be seen by a clinician was 11 hours.

The ED did not have a same day emergency care (SDEC) for patients, which is now a mandated pathway for patients and would assist in taking patients away from the overcrowded department. There had been discussions about opening an SDEC but there was no definite timeline known to the staff we spoke with as to when this might be established in the service.

Is the service well-led?

Requires Improvement   

Leadership

On the whole, local leaders had the skills and abilities to run the service. They understood and worked to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior leadership team for the ED was led by a head of nursing, an operations director and a clinical director who were all experienced leaders with strong decision-making abilities and had the appropriate levels of operational knowledge to lead the department in pressurised circumstances.

Urgent and emergency services

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They were largely able to articulate the challenges within the department.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times and moving staff around the department to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate.

The leadership team was able to talk about the challenges the department faced which were flow, patient demand and department capacity. The leadership team did understand the challenges that increased demand and capacity had on the quality and sustainability of the service, recognising that some of the challenges related to the wider healthcare system.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to 'grow their own' senior staff. Nurses told us they were encouraged to apply for more senior roles within the department. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and the support of good teamworking.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Trust and service leads acknowledged the ED flow, capacity and demand remained an ongoing risk. Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions.

It was not possible to mitigate all the risks associated with running an emergency department in light of the increased demand the ED had been working at for an extended period of time. With the numbers of patients waiting sometimes up to 11 hours to be seen, and others waiting over 80 hours for a bed to become available in the hospitals, it was difficult to have thorough oversight of every patient. Opportunities existed for patients to deteriorate rapidly without being detected. For example, in the waiting area, not all patients had their early warning scores, or pain scores reassessed in line with guidelines.

Hospital flow was recognised by the senior leadership team as a serious risk to the department's ability to provide safe care and treatment and achieve the performance standards required by both the royal colleges and NHS England. There was an action plan which focussed on improving this. The plan was updated regularly, and the key interventions were priorities by the trust.

The risks of running the department without sufficient staffing were recognised, and recruitment attempts were ongoing, particularly to nursing roles. The service used bank and agency staff to work towards mitigating this risk. Further risks of running the department without always having the necessary skills were also recognised. For example, the lack of senior medical staff meant the required regular review of patients were not always undertaken. Recruitment of consultants in the main ED had been successful with three new consultants having recently joined the service. However, we did not see any evidence of recruitment for paediatric consultants. There were significant gaps in paediatric consultants in the children's ED.

Urgent and emergency services

The risk that staff were unable to see patient observations on the IT system without logging into a further system, made managing the most unwell patients in the department a much harder task. There was no solution to this matter in place or being worked on as far as we could gather from our information request or discussions with staff. The use of the mixture of paper and electronic notes made making clinical assessments more difficult for staff.

The service also did not have a clinical decisions unit pathway through the ED because they were unable to staff the area. Combined with the lack of an SDEC, this made worse the already lengthy delays. The trust's other ED had an SDEC pathway, but this pathway had not been implemented at King George hospital which lead to variations in care for patients.

Medical care (including older people's care)

Inspected but not rated ●

Is the service safe?

Requires Improvement ● ↓

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, principals of good hand hygiene were not always met.

Ward areas were clean and had suitable furnishings which were well-maintained. All areas we visited had floors, walls, curtains, trolleys and working areas visibly clean.

The service performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas.

The IPC team completed joint divisional audits for geriatrics and specialist medicines on a quarterly basis. The audit assessed the environmental compliance with IPC standards. Data for the care of elderly wards showed that the divisional average for quarter one (April to June 2022) was 96% and 98% for quarter two (July to September 2022). In comparison, data for specialist medicines showed that the divisional average for quarter one was 83% and 90% for quarter two.

IPC nurses also completed monthly IPC clinical audits. These included the monitoring of peripheral catheters, central lines, urinary catheter and assessing compliance against MRSA admission screening and the use of bowel charts. The divisional average for the care of elderly wards was 90% for quarter one and 94% in quarter two. In comparison, the divisional average for specialist medicines was 81% for quarter one and 77% for quarter two.

The service had reviewed the findings of the IPC audits and used the findings to develop an action plan to improve care to patients in the specialist medical wards. The service developed an IPC clinical audit action plan which looked to monitor that appropriate actions were implemented and problems rectified with a 2 week review period. The action plan also sought assurances that issues of concern had been resolved and a summary of results were reported at the Divisional Quality and Safety Group.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had enough PPE and staff followed the trust's policy when supporting patients. This included wearing masks, aprons, gloves and face shields where necessary. Hand sanitiser and washing facilities were available on all wards. Signage advising staff and visitors to follow infection control practices, when entering and leaving ward areas was clearly visible and followed by staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed appropriate isolation notices on side room doors which were closed.

Medical care (including older people's care)

Cleaning schedules were up-to-date and demonstrated that all areas were cleaned regularly.

The service screened patients for potentially infectious diseases on admission such as Covid-19 (when showing symptoms or high risk/ vulnerable patients), *influenza* (when showing symptoms), methicillin-resistant staphylococcus aureus (MRSA) and methicillin-susceptible staphylococcus aureus (MSSA).

Staff did not always follow principals of good hand hygiene. During the inspection we observed 20 interactions of staff with patients and if staff followed good elements of hand hygiene. Of the observed interactions 12 members of staff washed their hands before and after patient contact. However, on 8 occasions, principals of good hand hygiene were not met.

Hand hygiene audits were completed monthly by the wards. Data for the care of elderly wards showed the divisional average was 96% in quarter one and 94% in quarter two. In comparison, data for specialist medicines showed that the divisional average for quarter one was 75% and 71% for quarter two.

As with the IPC audits we saw the service had reviewed the findings of the hand hygiene audits and used the findings to develop an action plan to improve care to patients in the specialist medical wards. This plan followed the same governance principals as the IPC action plan.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All wards we visited had separate male and female bays, with separate toilet and washing facilities allocated to each bay. Entry into and out of the ward was secure with swipe access to maintain a secure environment. Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards.

Wards had facilities to isolate patients and staff closed doors to treat patients who were at risk of infection.

Staff carried out daily safety checks of specialist equipment. This included safety checks of specialist equipment such as resuscitation trolleys and emergency equipment such as defibrillators. We reviewed 3 resuscitation trolleys and found all to have the appropriate checks.

Equipment was routinely, serviced and calibrated. We reviewed 15 pieces of equipment and all had identifiable records that servicing and maintenance was within date or had been completed within expected timeframes. Equipment storerooms were well organised and clean with secure access. Fire extinguishers were stored securely and in date throughout the service.

Piped oxygen and suction equipment were available at each bed space and oxygen cylinders were stored securely.

Staff disposed of clinical waste safely. We saw that bins were clearly labelled and the correct bin liners were used. We also saw that needle sharps bins were available throughout the wards and the 5 bins we inspected were correctly labelled and stored correctly.

Patients could reach call bells and staff responded quickly when called. Staff used the call bell system and ensured that patients had these within reach when necessary. During the inspection, we observed staff answer call bells promptly

Medical care (including older people's care)

and patients' needs were responded to. Patients we spoke with also told us staff responded to call bells promptly. However, we did notice that some call bells were not operational in Beech ward. When bringing this to the attention of the relevant ward matrons we were assured that all bays had an assigned nurse station where it was clearly identified which bells were not operational. We were also assured that all call bells that were not operational were identified by the nurses and notified to the maintenance team for repair. Some call bell repair requests had been in place for 3 days.

The service had enough suitable equipment to help them to safely care for patients. Staff we spoke with did not report any shortages of equipment. Some staff did however mention that clinical recording areas such as computer station and writing areas were sometimes cramped and too small for the number of staff present on the ward.

The service had suitable facilities to meet the needs of patients' families.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Staff mostly completed and updated risk assessments for each patient and removed or minimised risks when these were identified. However, in the gastroenterology service we found that key monitoring and assessment tools were not completed and follow up actions not recorded in the appropriate records.

Staff used risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly. The service used a seven-day booklet to capture mandatory patient assessments, planning and evaluation. This included a range of risk assessments such as falls, nutrition, skin, venous thromboembolism (VTE), continence, cognitive, and the Braden Scale (used to predict pressure sore risk). During the inspection, we checked 15 random patient records and found that risk assessments had been mostly completed, signed and actioned. However, in the gastroenterology service in Gardenia ward we found that key monitoring and assessment tools were not fully completed or signed. When reviewing 3 gastroenterology patient records we found that the malnutrition universal screening tool, food intake charts and clinical assessments were incomplete. Additionally recording of follow up action was not written in the appropriate records and there were gaps in the recording of crucial care records such as the food intake chart. This meant that patients were at risk of not having the best treatment options and staff could be unable to make safe decisions regarding the care of patients using the information that was presented to them. We requested local auditing of record keeping for the past 12 months for this area but were not provided with the information requested.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. We checked 5 random patient records and saw that appropriate escalation had taken place when required. We reviewed the NEWS2 audit results for the last 12 months for both specialist medicines and geriatrics and frailty. We found that both divisions did not consistently meet the trust target of 95%. However, the trust submitted action plans for both departments to address the inconsistent compliance. The timeframe for the action plan was between November 2022 and January 2023.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Nursing and medical staff were able to describe the signs and what treatment should be initiated in line with national and local guidance. This included awareness of the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients. The service had a sepsis trolley to support patient care.

Medical care (including older people's care)

We were assured staff kept patients safe from the risk of falling. We reviewed the falls recorded in 5 wards (2 elderly care, 2 specialist care and MAU) over the previous 3 months to our inspection. For the month of August a total of 3 falls were recorded in the 5 wards we reviewed, with 2 in September and 1 in October 2022.

We also reviewed the number of pressure sores recorded in the same 5 wards in the 3 months prior to our inspection. For the month of August a total of 2 pressure sores were recorded in the 5 wards we reviewed, with 2 in September and 1 in October 2022. We were told by staff that the trust had implemented a pressure sore plan to reduce the number of pressure sores occurring in medical wards.

The trust pressure ulcer and VTE reduction annual workplan (from April 2022 to March 2023) listed actions under five priorities and most of the actions were either rated amber (in progress) or green (achieved). We found that each listed action had progress reported against it and that details of further activities needed, timescale, intended outcome, progress, key performance indicators and ratings were also part of the workplan.

Staff shared key information to keep patients safe when handing over their care to others. We observed consultant and board rounds in 3 wards and saw that there were comprehensive discussions for each patient's treatment plan and assessments. We also saw that shift changes and handovers included all the necessary key information to keep patients safe. We observed a nursing handover where staff discussed patients in detail including information on patient observations, medications, overnight status, any deterioration and family contact.

The service had access to a dedicated safeguard team to support them in managing and referring any concerns or risks that were highlighted during periods of care.

The service had access to a mental health team and medical staff could also access support from the psychologist. Staff described how they would access the mental health team should they have any concerns. However, staff stated that they needed more support in this area as the complexity and number of patients with mental health needs had increased significantly post-pandemic.

Nurse staffing

The service ensured there were enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service ensured there were enough nursing and support staff to keep patients safe. Senior nursing leads could adjust staffing levels daily according to the needs of patients. Staff told us that staffing levels were regularly reviewed and increased where needed to keep patient care safe by using bank and agency staff to fill gaps.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a safer staffing tool to monitor staffing levels and ensured that staff were delegated appropriately across the service. The service had regular meetings that reviewed staffing levels across the division and ensured that all areas had sufficient staffing levels. There was also a monthly Divisional Review of Rostering Performance chaired by the trust Director of Nursing for Workforce Safeguards. Future rosters were interrogated, and actions were identified to optimise staffing over the future roster periods. The senior nursing team had daily huddles to review staffing, activity, concern and key messages from overnight.

Nursing staff said they felt nursing levels were safe despite the challenging environment that they worked in.

Medical care (including older people's care)

The trust provided data for nursing staff sickness, vacancy and turnover rates between November 2021 and October 2022, as monthly percentages. We obtained information for nursing staffing levels for elderly care wards at King George Hospital but not for other wards such as the speciality wards. Because we were unable to compare the data to other wards on the site, we did not use this data and reported it at a trust level.

For specialist medicines, the yearly averages for nursing staff was 4.6% for sickness, 11.2% for vacancy and 8% for turnover. The yearly averages for nursing support staff was 8.9% for sickness, 9.8% for vacancy and 13.1% for turnover.

For geriatrics and frailty, the yearly averages for nursing staff was 6.4% for sickness, 19.6% for vacancy and 11.4% for turnover. The yearly averages for nursing support staff was 6.9% for sickness, 18.9% for vacancy and 9.4% for turnover.

For assessment and ambulatory care, we were provided with trust wide data as the data could not be reliably split by site due to cost centres not being specific. The yearly averages for nursing staff was 6.4% for sickness, 30.1% for vacancy and 8.9% for turnover. The yearly averages for nursing support staff was 11.2% for sickness, 7.9% for vacancy and 9.8% for turnover.

Divisional leads told us that recruitment was always ongoing and nurse staffing remained on the risk register. The service was in the process of recruiting international nurses. However, retention was a constant challenge.

We requested data for bank and agency usage for nursing staff. The trust presented the data as the number of bank and agency shifts by month, for each division and split the data into qualified nurses and unqualified nursing. The time period for the data was between November 2021 and October 2022. Both geriatrics and specialist medicines used bank and agency staff with the most usage in the specialist medicines. For geriatrics, 26% of qualified nurses shifts were unfilled in comparison to 17.8% for unqualified nursing staff. For specialist medicines, 22% of shifts for both qualified nurses and unqualified nursing staff were unfilled.

Managers made sure all staff including bank and agency had a full induction and understood the service. We spoke with 2 new starters who told us that their induction was detailed and that they received support from the team. Senior leads told us that inductions included a 2 week supernumerary phase (after the trust induction) and new starters received a welcome induction pack.

Medical staffing

Although the service had consultant vacancies, it worked to ensure there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We reviewed the rota for the six weeks before our inspection and although wards had been mostly sufficiently staffed, staffing levels matched minimum requirements. This meant that challenges could occur if there was sickness within the staff group. We were told shortages were mainly at consultant level. These were due to departures from consultant staff as well as national shortages.

Between August and October 2022, consultant vacancies by speciality that were relevant to King George Hospital were, respiratory (18.2%), cardiology (16.7%). We requested the vacancy rates for gastroenterology but this was not provided to us.

Medical care (including older people's care)

The trust provided the bank and agency usage for medical staffing between November 2021 and October 2022. The data was presented as monthly figures split into three areas: geriatrics and frailty, specialist medicines and assessment and ambulatory care. All three areas used bank and agency staff with the most usage in the geriatric's division. Data showed that 21% of shifts were unfilled in geriatric and specialist medicines in comparison to 33% in assessment and ambulatory care. However, although managers could request locums when needed, divisional leads told us that the reduction in agency pay and absence of London waiting allowance, hindered the fill rate of shifts and had caused locums to leave the division.

The trust provided data for medical staff sickness, vacancy and turnover rates between November 2021 and October 2022, as monthly percentages split. The data was not site specific and the trust target was not included. The yearly averages for medical staffing (career grades) was 1.5% for sickness, 23.8% for vacancy and 2.9% for turnover. The yearly averages for medical staffing (training grades) was 4.6% for sickness and 17.8% for vacancy.

Senior leads told us medical staffing was on the risk register. Staff told us that consultant vacancies had led to delays in completed electronic discharge summaries, delays in specialist referrals on wards and missed training opportunities for doctors due to the workload pressures. This was particularly evident in the gastroenterology ward. However, junior doctors, senior house officers and registrars told us that they could always access support from a consultant when needed.

The trust were reviewing the consultant model by arranging peer reviews with nearby NHS hospitals and having regular engagement meetings with the medical staffing in the service. Divisional leads told us that during the pandemic, registrars had stepped up to consultant level but could not independently look after a ward without a Certificate of Completion of Training (CCT) for consultant. Despite the work pressures, medical staff we spoke with remained passionate about their work and still enjoyed coming to work.

Managers made sure locums had a full induction to the service before they started work. Divisional leads told us that inductions for locum consultants were managed by the service manager.

Is the service effective?

Inspected but not rated ●

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Examples included, but were not limited to, the National Early Inflammatory Arthritis Audit and the National Lung Cancer audit.

Performance in national outcome audits were variable. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required.

Managers and staff used the results to improve patients' outcomes. Staff were aware of audit results and were able to reflect on things that had gone well and that needed to be improved. Divisional leads told us that specialties discussed audit results and actions at multidisciplinary meetings. Staff were knowledgeable of relevant national audits and were able to talk about how their work contributed towards a culture of improvement.

Medical care (including older people's care)

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took actions to prevent them. Trust data was provided for delayed discharges between May 2022 and October 2022 with the reasons for delay. Although there were numerous reasons for delay, the top four reasons included awaiting place for nursing or residential home 13.5%, awaiting rehabilitation bed 9%, awaiting restart/increase in long term package of care 7.7% and family delay 7%.

Data for number of patients discharged out of hours (between 8pm and 8am) showed that between October 2021 and October 2022, there were 1844 discharges at King George Hospital.

The service used seven-day nursing bundles to improve patient outcomes. Examples included, but were not limited to, falls, pressures sores and catheter risk assessments. This clinical data was audited and monitored to improve patient quality of care and improve patient outcomes.

The service organised mortality reviews for complex patients. Senior leads told us this was led centrally and included all the relevant specialities. The service had an associate medical director (AMD) who led on the learning reviews from deaths.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Multidisciplinary meetings included handovers, consultant and board rounds. These were attended by nurses, nursing associates, doctors' assistants, physiotherapists, doctors, occupational therapists, senior nursing staff and discharge coordinators. Discussion in these meetings included patients' diagnosis, treatment plans and diagnostic investigations, social placements, concerns and any discharge planning.

The emergency department medical clerking and post take ward rounds, as well as decision to admit handovers, were comprehensive and supportive of the handover process. The teams worked well together with documentation for the medical clerking and post take ward round being thorough. We saw that for medical patients who were in the emergency department (day 2), there was clear ownership of these patients by the medical speciality registrars. Emergency department nursing staff were very clear as to who to contact if a medical patient still in the ED deteriorated.

Patients had their care pathway reviewed by relevant consultants. Senior nursing leads told us it was easy to make referrals to specialist teams for support. Staff told us that MDT meetings would be arranged as needed to discuss complex patients and all the relevant departments attended.

MDT meeting minutes for hospital flow were well recorded. We found that each meeting had an attendance log and action log. The action log included information on actions needed, named owner, target completion date, status and comments.

The service undertook regular operational flow meetings and surge call meetings during each day. These were well attended by representatives of each ward and operational managers.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff we spoke with during our inspection were aware of the mental health liaison teams and divisional leads told us they were working closely with the mental health provider focusing on the priorities for winter.

Medical care (including older people's care)

Seven-day services

Most of the key services were available seven days a week to support timely patient care. However, some services were not fully operational on weekends.

Divisional leads told us that there was a medical on call team including senior medical staff, which was available on weekdays, and on call out of hours and weekends. The service had duty matrons shifts on weekends across the hospital and these shifts came around every two months. Similarly ward managers also had on call shifts every two months.

Staff could call for support from doctors and other disciplines, including physiotherapy, diagnostic tests, imaging, palliative care and infection prevention and control team, seven days a week. Staff told us that urgent imaging could be arranged at night and weekends if needed. Staff told us that they could easily access and manage test results and investigations results using the electronic system.

The pharmacy team provided a full service from Monday to Friday with evening and weekend cover managed by an on call pharmacist and a site manager (for access to emergency medicines). Ward staff told us that they would like to have a dedicated pharmacist but this wasn't possible due to vacancies in the pharmacy workforce. The only ward with a dedicated pharmacist was Beech ward.

The mental health liaison service was provided by a community mental health provider. The service included emergency (one-hour response) assessments and routine (24hour) reviews. Staff were able to make referrals easily and contact the team for emergency/ urgent assessments.

The service had a dementia and delirium team which was available Monday to Friday. Staff told us that they could access the medical consultant out of hours if needed. Although the learning disability (LD) lead was only available Monday to Friday, senior leads told us that all matrons had completed LD Level 3 training so that they could provide out of hours cover on evenings and weekends. Patients also had LD hospital passports.

The dietetic service was available Monday to Friday 9am to 5pm with no weekend cover. Staff told us they had good access to the speech and language therapists (SLT). Staff reported good access to the tissue viability nurses (TVN) and told us that the TVN's report was included in discharge summaries and could be shared with care homes if needed.

Occupational therapists (OT) were available Monday to Friday 9am to 5pm with no cover in the evenings and weekend. Staff told us this was due to OT vacancies which affected the trust and was an issue nationally.

The trust offered psychological support for their staff which was managed by occupational health. The service provided both assessment and treatment for staff experiencing complex trauma.

Is the service caring?

Inspected but not rated



Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection, in all the areas we visited, we witnessed staff interacting positively with patients and answering patients' and relatives' questions.

Staff followed policy to keep patient care and treatment confidential. Staff used curtains or privacy screens where needed to maintain patients' privacy and dignity. We saw that when a patient was being examined, the curtains were drawn around the patient to maintain privacy and the dignity of the patient.

We observed staff interact with patients living with dementia in a calm and caring manner.

Patients said staff treated them well and were very caring. Feedback from patients noted how they felt safe and comfortable in staff's care.

Staff displayed thank you cards for the public to view. The service also recorded comments received via feedback cards. Some patient comments included: "Good care and lovely staff", "I felt safe in your hands" and "I felt kindness, love and spirit".

Friends and Family Test (FFT) results for geriatrics and frailty showed that from 1074 responses, 92.8% were positive. Results for acute medicine showed that from 460 responses, 89.6% were positive and for specialist medicines, 2085 responses were received of which 93.6% were positive.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition. However, the majority of patients we spoke with did not feel they were sufficiently involved in making decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us that staff kept them informed of their treatment plans, medication changes and staff change for both nurses and doctors. However, of the 15 patients and close relationships that we spoke with, 11 said they didn't feel part of the team and were mostly told what would happen next. Patients stated they wanted to be more involved in the decision making process of their care and discharge planning.

Discharge coordinators liaised with families to inform them when patients were due to arrive home. Information on discharge planning, what happens before discharge, what happens on the discharge day and a to-do checklist were also shared with families and care agencies.

The service had a discharge leaflet that included contact information for the ward where the patient was discharged from and details of either home care package or assistance from social services if they had been arranged. Staff told us that either nursing or medical staff completed follow up calls with the patient post discharge.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. Patients were also able to make suggestions to improve the service.

Is the service responsive?

Inspected but not rated



Medical care (including older people's care)

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. However, divisional leads told us that the service was working at high capacity because the population the trust served had increased and continued to do so and the hospital's capacity remained the same.

Facilities and premises were appropriate for the services being delivered. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Patients received comprehensive assessments by specialist multidisciplinary teams tailored to their needs. This prevented duplication of assessments by multiple specialities as there was a standardised MDT screening process to support patient care.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service had a variety of specialist link nurses who were available to offer advice and support to staff and patients. Examples of link nurses included, but were not limited to, pain, dementia and delirium, mental health and learning disabilities.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia.

The service understood the needs of the local population which had a high proportion of elderly patients. As an example, the service developed a tailored frailty unit at King George hospital which provided a triage centre for elderly patients who arrived by ambulance at the hospital and met the admission criteria. The unit also provided a fit to sit area, a dedicated pharmacist and outpatient follow up appointments for patients who were safe to be discharged and could return to hospital for their follow up appointments.

Staff talked with patients, families and carers using communication aids where necessary. Staff said they had access to communication aids, and these were used to help explain care to patients who may have difficulties with expressing how they were feeling or were living with dementia.

The service used blue wrist bands for identification of patients living with dementia. The service used the Butterfly scheme and offered reminiscence interactive therapy and activities (RITA) on wards to support patients. RITA is a tool that helps patients recall memories, patients relax in the hospital environment and encourage conversation and interaction between patients, their family and staff.

Staff had access to translation services where needed.

Access and flow

Although most people could access the service and received the right care, wider system issues impacted the hospital's flow and led to delays in discharge. The service continued to work at capacity to reduce waiting times for referral to treatment times.

Medical care (including older people's care)

Managers monitored waiting and handover times. However, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. Divisional leads told us that although the population the trust served had increased and continued to do so, the hospital's capacity remained the same. The trust was working on continuously improving flow with projects such as the Red2Green Team, the use of ambulance handovers in the frailty unit and the assignment of dedicated discharge coordinators for each ward.

We saw good communication and handovers of patients admitted from the emergency department (ED) and transferred to the medical wards. On the days of the inspection there was a medical consultant, medical speciality registrar (SpR) on call and a post take senior house officer (SHO) seeing medical patients in the ED. Documentation for the medical clerking and post take ward round was thorough and easily accessible. ED nursing staff were very clear as to who to contact if a medical patient still in the ED deteriorated and felt that when this occurred the patient was then reviewed in a timely manner. However, there were some issues that could potentially impact on flow such as, there was no specific post take senior house officers or junior doctors which meant there could be delays in ordering investigations and in the management of patients until the patient moved to the medical admissions unit.

The service had a frailty unit which helped streamline patient flow and discharge by supporting the ED in admitting and triaging pre booked ambulance arrivals that would otherwise attend the ED. These patients were screened and a strict list of criteria determined if they were medically appropriate to attend the frailty ward and be assessed there rather than the ED. Additionally, the frailty unit arranged relevant follow up tests and assessments for patients to return to the ward if patients were safe for discharge. This meant patients did not have to spend longer time in hospital than necessary. The unit also worked closely with the emergency department to ensure any social services referrals were made at the outset of a patient's admission.

The frailty unit doubled as a medical care unit. Senior staff explained to us how one side room was used as a discharge lounge for patients awaiting medications ahead of discharge as well as a fit to sit treatment area. This meant the frailty unit was able to flex to the needs of the patients and promote flow through the service without impacting the ED, discharge lounge or other medical wards.

The medical admission unit (MAU) received direct admissions from ED. Staff told us that patients could stay up to three days in the MAU before getting transferred to wards.

The service had daily meetings such as huddles and bed meetings where access and flow were discussed at a ward level. Ward managers and discharge coordinators worked to prepare patients for discharge once care had been coordinated between the multidisciplinary team. However, ward discharge coordinators only worked 5 days a week from Monday to Friday limiting discharge activity over the weekend.

Managers and staff started planning each patient's discharge as early as possible. The Red2Green team was comprised of discharge coordinators who focussed on discharge pathways out of the hospital with community partners. The team worked closely with the wards and attended board rounds to reduce any delays to patients being able to leave the hospital. The team had a daily conference call with system partners to speed up patient discharge. We attended the daily call and found that comprehensive discussions took place for each ward by site. On inspection, we observed the presence of dedicated discharge coordinators on the care of elderly and specialist wards who were assigned to promote improved flow from the wards.

Medical care (including older people's care)

However, staff told us there were still several constraints that impacted flow within the medical services. As an example, some medical specialities did not have 7 day consultant presence in the service. This had a great impact because, mainly during weekends, discharges were not completed and discharge summaries not signed. Additionally, some supporting teams for medical care such as pharmacy and therapy services only offered comprehensive services from Monday to Friday with an impact on discharge planning.

In addition to this, staff and senior leads told us that wider health system issues such as obtaining nursing home placements and social care packages contributed to delays in discharge. We were informed this was particularly evident over weekends and on Friday evenings. Therapy staff also told us that getting equipment to a patient's home was a challenge at times as part of discharge process. We requested specific data regarding day on day discharge numbers from the medical wards but unfortunately the service did not provide us with this information.

It was also felt by the inspection team that a culture of week-day discharge working had settled into the services we inspected, impacting the flow of the service over the weekend and carrying it over into Monday and Tuesday the following week. Staff and leaders were candid in saying that Mondays were the busiest days at the service as all the discharges accumulated over the weekend and admissions waiting in the ED had to be processed, as well as continuing to provide the care services. We were informed that as the week progressed the services managed to improve their discharges and flow to a point where on Friday the system was near optimal performance. This was then impacted again with the upcoming weekend reintroducing the same challenges. We requested day on day discharge data to corroborate this but the trust did not provide the data requested. We were informed on inspection that on average some of the wards we visited would do 8-9 discharges during the weekdays and this would reduce to 1-2 discharges over the weekend.

We found that the discharge lounge was underutilised. The discharge lounge was a 3 seated area that could be double to 6 seats and had a 2 bedded area. The discharge lounge only operated 5 days a week from 8am to 8pm and was nurse led. On the second day of inspection we visited this area and found that no patients had been allocated to the discharge lounge between 8am and 1pm. We were told that on average the discharge lounge would see 6-8 patients a day. This meant that flow through this area was very limited. Staff told us that the discharge lounge criteria had been amended to only include patients who were fit to sit on chairs with appropriate care plans, completed electronic discharge summaries (EDS), with to take away (TTA) medicines, confirmed, care home placements arranged and ready for discharge on the same day. Staff from the discharge lounge told us they proactively liaised with wards to see if any medically fit patients could be sent down to the discharge lounge.

Following the onsite inspection we issued the trust with a letter of concern. In response to our letter we were told that processes were going to be introduced so that every ward would have an agreed daily discharge target to support emergency care flow. These targets included addressing concerns of work over the weekends. Targets would be monitored regularly to ensure better discharge flow that day and subsequent days, including weekends. This activity was also aimed at supporting flow into the discharge lounge and increasing pre-midday discharges.

The NHS Constitution states that 'no-one should expect to wait more than 18 weeks from the time they are referred to the start of their consultant-led treatment, unless it is clinically appropriate to do so or they choose to wait longer'. We saw the geriatrics and frailty division had 189 patients awaiting appointments from which 87% had had appointments booked and the remainder, were in the process of being booked in. The division had 8.99% of patients breaching the 18 week referral to treatment (RTT) pathway. No patients were waiting beyond 52 weeks for this division. We also saw reports that in November 2022 speciality medicines such as endocrinology had a list of 78 patients who had breached the 18 week RTT. We did however see plans to address this and that 46 of the 78 patients would be seen in the next 4 weeks.

Medical care (including older people's care)

Is the service well-led?

Inspected but not rated ●

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had a leadership structure for both the specialist medicines division and geriatric and frailty division. The structure included divisional directors, divisional managers and divisional director of nursing. Senior leads told us that both divisions were due to merge as part of the trust's transformation changes by the end of March 2023.

Senior leads understood the challenges to quality and sustainability the medical care service faced and had plans in place to address them. Some of the challenges related to the wider healthcare system.

Staff demonstrated awareness of the leadership team and described them as visible. Service leads told us that executives were visible and approachable in the department. We observed matrons were visible on the wards and they were knowledgeable about the ward's performance and areas of improvement.

Most staff told us that managers were supportive and approachable, and felt their concerns were listened to. However, in the gastroenterology team it was felt by staff that the lack of a dedicated onsite consultant had led to increased workload pressure and staff missing out on training opportunities. We were told this had been raised several times but not addressed to the present date.

Staff showed awareness of freedom to speak up guardians should they need to raise a concern.

Although staff told us that the work pressure was fast paced, most staff reported a happy working culture and enjoyed coming to work. Most staff told us that they were supported to develop their skills. For example, healthcare assistants were encouraged to develop their skills by completing their nursing associate training following by registered nurse training.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented in risk management documentation. The divisional team described their top risks as flow, staffing and increased complexity of dementia patients. This was also highlighted by the King George Hospital medical site director and operations manager.

We reviewed the risk and compliance group meeting minutes between August 2022 and October 2022 and found risks and discussions around key points such as: outstanding risks, workforce, finance, corporate risk report, policy report and the central alerting system.

Medical care (including older people's care)

We reviewed the Specialist Medicine Division and Geriatric and Frailty division reports for November 2022. The reports detailed a summary of risks and we found that risks were appropriately documented with named risk assessor, risk score, risk controls and action plan. We saw that risks identified during inspection were on the risk register, including medical staffing, nurse staffing and the risk of violence and aggression or abuse to nursing and medical staff from patients with dementia or a cognitive impairment.

We reviewed the quality and safety meeting minutes for the geriatrics division between July 2022 and October 2022. The meeting agenda included discussion on outstanding risks, serious incidents, staff rota, updates from each area, staffing, complaints, clinical effectiveness, mortality review and patient feedback.

Each clinical medical area identified local risks through discussion at monthly quality and safety meetings where all staff could attend. During the inspection, we saw Quality and Safety Boards in all the areas that we visited which included information on incidents and learning. Senior leads told us that each area's risk were discussed at monthly governance meetings. This supported ward managers and matrons to keep an active and engaged monitoring of the local ward risks.

Senior staff told us that since the COVID-19 pandemic, the service had seen an increase in patients presenting more confused with progressed dementia and often displaying aggressive behaviour. Additionally, we were told that the medical complexity of the patients had also increased with patients presenting progressed conditions and a higher number of unmanaged comorbidities. This presented a challenge to staff who had to cohort patients on the bays appropriately and manage more complex caseloads and discharges, impacting on the hospital flow. We heard of plans and ongoing liaison with external partners to address these risks.

The flow and management of beds was reviewed daily by the site operational manager. An operational flow meeting was held 3 times daily and a surge meeting held twice daily to address staffing and flow risks. The service used a real time display highlighting staffing needs, admissions and discharges and a Red to Green system to support their decision making.

The service worked closely with social services and community services to manage system wide risks that could affect the hospital. We heard that due to the increasing number of patients attending the hospital and the impact this had on flow and access to care that the service was working with these external partners from a ward to board level to increase integrated care management and discussing improving access to their services.

The senior nursing team had regular meetings with the triumvirate team. In addition, the service had weekly tracker meetings which reviewed risks, complaints and incidents for both trust's sites. Ward managers had weekly meetings across both trust's sites.

The trust had a Local Emergency Preparedness Policy which was in date. The policy ensured the trust was prepared for an emergency or natural disaster. It supported business continuity management systems and continuity planning, especially in events of hospital issues.

Diagnostic imaging

Requires Improvement 

Is the service safe?

Good 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. We reviewed evidence of mandatory training records provided by the trust. We found most staff groups were above the mandatory training target for 90% compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules provided to staff included life support training to the appropriate level for each staff group, Safeguarding, Equality and Diversity, Fire Safety, and Information Governance. Mandatory training was a mix of classroom based training and online training.

Managers monitored mandatory training completion through supervision and the online training system, and alerted staff when they needed to update their training. Staff stated they were informed by managers when they needed to attend and update their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Clinical and administrative staff both completed the appropriate level of adult and child safeguarding training in line with national guidance.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of when they would need to raise a safeguarding concern and what specific issues they may need to look out for (such as child abuse, domestic violence, and female genital mutilation). Staff followed safe procedures for children visiting the service /department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff in diagnostic imaging areas had access to safeguarding support and advice through local and hospital safeguarding leads. We observed numbers for contacting safeguarding support in communal staff areas.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We inspected communal patient and staff areas as well as clinical rooms in diagnostic imaging areas and found them to be visibly clean.

Diagnostic imaging

The service generally performed well in audits for cleanliness. The Radiology Department provided evidence of their completion of a six-monthly divisional infection prevention and control (IPC) assurance audit. The audit included standards for environmental cleanliness, hand hygiene, use of PPE, decontamination, waste management, and staff practice. Where the audit identified standards were not met, the audit tool included an action plan to be completed to improve practice within agreed deadlines.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning logs on site which showed that cleaning was completed with daily and weekly checklists. The trust also used an IPC monitoring software program which could produce quarterly reports on IPC compliance. We reviewed evidence of these reports following inspection and found they included comprehensive review of IPC practice within diagnostic imaging areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). All clinical staff on inspection were bare below the elbows and cleaned their hands between patient contacts. Staff continued to use face masks when working with patients or moving between clinical areas to mitigate risks associated with COVID-19. The trust also provided evidence of monthly spot checks for hand hygiene.

Diagnostic imaging areas had specific IPC practices in place to manage risk related to COVID-19. IPC practices we observed were in line with national guidance. Communal areas for patients included access to face masks and hand sanitiser, and staff were encouraged to observe IPC practices throughout the hospital.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. IPC audits included assurance sections on equipment decontamination, and staff ensured that clinical equipment was appropriately cleaned between uses.

The service had comprehensive decontamination policies in place to ensure equipment and the clinical environment was kept clean. The decontamination policies reflected the specific needs of each modality.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The Radiology Department at King George Hospital had seen significant investment in the estates and equipment in the last two years. This was to align with the long-term plan to transform the service delivery into a community diagnostic hub for the three boroughs served by the trust. This included a refurbishment of areas for Magnetic Resonance Imaging (MRI) and Ultrasound, and new rooms for Ultrasound and X-ray at King George Hospital. The service had also significantly increased the extent of the imaging equipment including new CT scanners and a 3T MRI Machine.

The design of the environment followed national guidance. The layout of communal and clinical areas was in line with NHS England Health building notes guidance. Diagnostic imaging rooms had appropriate space for examination and scanning, and communal areas were appropriate for patients and other visitors waiting for appointments.

Staff carried out daily safety checks of specialist equipment. The trust maintained equipment maintenance logs to monitor when diagnostic imaging equipment was last maintained and calibrated. On inspection we observed that imaging equipment was within its period of maintenance date and had been recently completed an annual quality assurance check. After inspection we also reviewed quality assurance reports which showed that imaging equipment was safe for use.

Diagnostic imaging

All clinical staff had received appropriate training in the use of equipment. Staff completed training modules in safe use of equipment, and competency evaluations were completed for staff using imaging equipment as part of the induction process within the radiology department.

Clinical areas that had medical equipment had measures in place for their safe use, in line with legal requirements and best practice for equipment safety. There was clear signage showing where equipment may be a risk to patients, and when that equipment was in use.

The radiology department completed an annual personal dosimetry audit to ensure that employees were not exceeding annual dose limits of ionising radiation. All staff working with ionising radiation were issued with dosimeters to ensure compliance with Ionising Radiation Regulations 2017. At King George Hospital the most commonly issued dosimeters were chest and collar badges. The 2021 annual dosimetry audit stated that assessment of maximum doses suggested no dose limits or investigation levels have been exceeded, and that no members of staff need to be classified. The audit also included recorded actions to improve future compliance.

MRI equipment was labelled in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety guidelines for MRI equipment in clinical use. This included clearly displaying information where items and equipment were safe or unsafe for use with MRI equipment.

The MRI area for the radiology department displayed information showing the limit of the "5 Gauss line" and it was clear from the evidence provided how the risk to patients and staff was being mitigated. The 5 Gauss line shows the area around an MRI machine at which the magnetic fields are more than five Gauss, a measure for the strength of a magnetic field. This is an important safety consideration as when the magnetic field is equivalent to or over five Gauss, it can present risks to patients and staff (as it affects devices such as pacemakers and implantable cardioverter defibrillators).

Following inspection, the trust provided evidence of the plotted five Gauss line for the MRI machine, which suggested that a magnetic field over five Gauss extended into the adjacent equipment room when the MRI machine was in use. The department managed this risk by providing risk assessments for staff and clearly displaying warning signs on the door of the equipment room.

The service had suitable facilities to meet the needs of patients' families. Waiting areas in the radiology department had suitable seating for visitors and amenities were available on site.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation equipment had been safety checked and was subject to monitoring. Staff carried out daily safety checks of specialist equipment.

Staff disposed of clinical waste safely. The service had a waste management policy, and waste was segregated with separate arrangements for general waste and clinical waste. Sharps equipment, such as needles, were disposed of correctly in line with national guidance.

Control of Substances Hazardous to Health (COSHH) risk assessments had been completed. The COSHH assessment outlined the risk involved and measures to mitigate the risks and actions to take in the event of an accidental spillage. The department had access to spill kits if needed to respond to hazardous substances.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Diagnostic imaging

Staff responded promptly to any sudden deterioration in a patient's health. If a patient became unwell in the radiology department, there was a clear protocol to follow and numbers to contact were visible in communal areas. Staff we spoke with were clear on how they would escalate if a patient was deteriorating, and stated that the response from the medical staff would be prompt. Staff could also access the Critical Care Outreach Team (CCOT) if needed, which was available Monday to Friday between 9am and 6pm.

Staff completed risk assessments for each patient and reviewed the suitability of the process regularly. Patients completed a screening process with staff to identify any potential risks that may impact the delivery of care or present potential harm to patients.

The radiology department had access to the trust radiation protection service. The radiation protection advisor (RPA) and medical physics expert (MPE) provided oversight for safety and assurance in relation to radiation and medical physics for diagnostic imaging.

On inspection staff were not clear on who the allocated radiation protection supervisors (RPS) for the radiology department were. This was consistent across staff groups we spoke with, and information on who the RPS was for each area was not readily available. Radiation Protection Supervisors told us they had not had consistent training and had not been carrying out functions in relation to this role. This meant staff may not be sure who to contact if they needed advice on radiation safety.

On inspection we did not see evidence of emergency evacuation procedures for the radiology department. We also did not see consistent evidence of visible emergency evacuation information for patients in communal waiting areas. This meant that we were not assured that there were specific emergency evacuation plans for the radiology department. However, following inspection, the trust provided evidence of staff completion of fire safety training and the trust business continuity and major incident plans.

Staff shared key information to keep patients safe when handing over their care to others. We saw evidence in patient records of information being shared with other healthcare providers involved in patients' care.

The Radiology Department used the Society of Radiographers "Six Point Paused and Checked" Patient ID check prior to radiological investigation. This allowed the clinicians to ensure patient information was accurate, that any patient risk factors identified could be acknowledged, and that exposure was safe for the patient.

Radiology staff provided evidence of risk assessments for Ionising Radiation assessments for pregnant people or other groups more at risk from ionising radiation. This allowed the service to ensure the risk to specific individuals could be mitigated.

Shift changes and handovers included all necessary key information to keep patients safe. On inspection we attended a morning huddle for the radiology department that looked at looking at staffing issues, any other risks, and information that may impact service delivery. We also attended a morning handover which appropriately discussed staff allocation, changes to practice, and any other information staff needed to know for their shift.

Radiography Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Diagnostic imaging

The service had enough radiographers, sonographers and imaging support staff to keep patients safe. Staff were separated into teams across eight clinical modalities: plain film (X-ray), computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound at King George Hospital, ultrasound at Queens Hospital, breast, medical photography, and interventional radiology. Each service had a modality lead who reported into the professional lead for the Radiology Department.

Staff levels were planned and reflected demand on the service and known treatment support needs. Rotas were completed in advance to align with activity, with short notice changes as required in accordance with staff levels. Modality leads could adjust staffing levels as required to meet the needs of the service. There was an operational morning huddle to discuss operational issues across the department including staff levels.

The number of radiography staff and imaging support staff matched the planned numbers. Staff stated across modalities that the services were generally capable of matching staff numbers to rotas. Staff and managers stated that this often required depending on the goodwill of frontline staff. Managers also stated there was temporary bank staff available.

The trust provided information on the vacancy rate for radiography staff. From May 2022 to October 2022 the Radiology Department demonstrated a reduction in the vacancy rate from 21% in May to 15% in October. Managers stated that recruitment of radiographers was a constant battle and challenging due to national shortages. However, the service had recruited ten radiographer apprenticeships and two mammography associates and had also successfully recruited radiographers through overseas recruitment.

The service had consistent turnover rates for radiography staff. Between May 2022 and October 2022, the Radiology Department monthly turnover rate for radiographers was consistently between 8% and 10%. Managers stated that the service was developing the training and career progression opportunities offered by the Department to help attract and retain staff.

The service had lowered rates of agency staff use. Managers stated that they preferred to utilise staff that were familiar with the service where possible, and that there was radiography bank or regular staff available if needed. The trust also had a "Trust Temps" programme which encouraged healthcare professionals to sign up as available bank staff.

Radiography staff we spoke with stated they generally felt valued. Some staff we spoke with stated that they would like the opportunity to rotate from their area to the other acute hospital site at the trust.

Managers made sure all bank and agency staff had a full induction and understood the service. We reviewed local induction policies for staff which included a process for inducting agency staff or Trust Temps.

Patients we spoke with were positive about the treatment they received from clinical staff. Parents stated that radiographers were supportive and patient-centred in appointments, and stated they were quickly available to answer any questions or address any issues they raised.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Diagnostic imaging

The service had enough medical staff to keep patients safe. Medical staff within the Radiology Department were separated into two groups (reporting radiologists and interventional radiologists) reporting into the clinical lead for Radiology.

Diagnostic imaging had access to radiology reporting 24 hours a day. This included access for emergency referrals. Between 9am and 5pm Monday to Friday imaging results were reviewed by the duty radiologists. Radiologist on-call cover was available 5pm to 8pm weekdays, and outside of these hours there was access to a teleradiology provider between 5pm to 8am for the Emergency Department, and 8pm to 8am for inpatients on weekdays. The service always had a consultant on call during evenings and weekends.

The service had low vacancy rates for medical staff. From May 2022 to October 2022 the Radiology Department medical staff vacancy rate was between 2% and 4%. Medical staff we spoke to stated that generally arranging radiologist cover was possible and there was additional cover possible from teleradiology services if needed. For example, the Radiology Department had outsourced some CT reporting to speed up the pathway.

Medical Radiology staff also had low turnover rates and low rates of locum usage. From May 2022 to October 2022 the Radiology Department medical staff turnover rate was between 2% and 4%. However, managers stated they could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. We reviewed local induction policies for medical staff which included a process for inducting locum staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed five sets of patient records and found they were generally well completed, and all staff could access them easily. The radiology department used an electronic patient record system (EPRS) and PACS (picture archiving and communication system) for diagnostic images. The EPRS was used to store patients' records.

Records were stored securely. On inspection we observed staff storing records securely in each clinical area and access to computers and EPRS systems was password protected. Information governance training was also mandatory for all staff working at the hospital.

We requested information on records audits for the radiology department. The trust provided information on a specific record audit carried out in 2021. However, we were not assured that there was a regular dedicated process for reviewing the quality and accuracy of information in patient records including for image quality.

The highest rated item on the Radiology Risk Register in August 2022 was "The PACS is slow loading images, current hardware hosting PACS has come to end of life. No longer performing as expected". In the November 2022 monthly radiology events and learning meeting (REALMs), actions had been taken to mitigate this risk and the risk was downgraded. As part of the departmental strategy, the trust was looking into a shared PACS system with a neighbouring acute trust within the North East London Integrated Care System (ICS).

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Diagnostic imaging

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed Patient Group Directions (PGDs) for sodium chloride and oxygen and found they aligned with best practice.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had an incident reporting and investigation policy, which staff we spoke with were aware of. This outlined staff responsibilities around incidents and how to report them.

Staff received feedback from investigation of incidents, both internal and external to the department. We reviewed minutes of departmental meetings which evidenced discussion of incidents. Staff we spoke with stated they had an opportunity to discuss feedback from incident investigations and that actions were taken to make improvements to patient care.

Staff reported incidents clearly and in line with the provider policy. Between October 2021 and November 2022, the King George Hospital Radiology Department reported two serious incidents and no never events.

In August 2022 the trust declared a Serious Incident in relation to the accuracy of their patient tracking list (PTL) and activity data for diagnostic imaging patients. More information on this issue can be found in the Well Led section under the Key Line of Enquiry (KLOE) for Information Management.

Staff understood the duty of candour. The incident policy included support for patients and their families to be involved in incident investigations if requested and the service had a duty of candour policy.

Managers shared learning about serious incidents with their staff and across the service, including about incidents that happened elsewhere. Staff stated that radiology was often part of the patient journey through hospital and so they would be informed of serious incidents in other areas involving patients who had an appointment in the radiology department.

Managers investigated incidents thoroughly. We reviewed evidence of investigations into incidents and found that learning to mitigate future risks and improve service delivery was identified and implemented. Patients and their families were also given the opportunity to be involved in the investigations.

Diagnostic imaging

Is the service effective?

Inspected but not rated ●

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Clinical guidelines and policies were kept on the intranet, however on inspection we found there was a lack of version control for policies, staff and management acknowledged this. We found examples of policy documents on the intranet that had not been updated or reviewed, and there were examples of multiple versions of the same policy from different years. This meant that staff accessing policies, procedures and guidelines on the intranet may be referring to guidance or processes that were out of date or did not reflect current practice.

The service tested for and recorded Diagnostic Reference Levels (DRLs) for diagnostic imaging services. DRLs are used as investigation levels to indicate abnormally high doses, as the aim of medical imaging is to attain diagnostic quality images whilst keeping radiation doses “As Low As Reasonably Practicable” (ALARP). The trust provided evidence that DRLs were carried out in imaging areas at King George Hospital.

The trust Radiation Protection Group (RPG) met twice a year and was responsible for the safe use of radiation producing diagnostic equipment and practice related to this equipment. Attendees included the Radiation Protection Advisor (RPA), Medical Physics Expert (MPE), modality leads, and the radiation protection supervisors (RPSs). We reviewed minutes from this meeting and found it had a consistent agenda overseeing radiation risk and governance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits however did not report results under Radiology. The trust stated Radiology and diagnostic imaging may regularly contribute to patient pathways related to national clinical audits, but that the result would not be reported in relation to the Radiology Department.

The trust was not currently contributing compliant with six weeks standard for a diagnostic test (referred to as the DM01). More information on this issue can be found in the Well Led section under the Key Line of Enquiry (KLOE) for Information Management.

Diagnostic imaging

Managers and staff did not appear to carry out a comprehensive programme of repeated audits to monitor improvement over time. We requested information regarding a regular audit programme and were provided with information on some informal and bespoke audits. Minutes from the Radiation Protection Group in December 2021 stated that all “non-COVID audits” had stopped, but it was not indicated when they would resume or when an audit programme may recommence. The trust Radiation Policy outlined the regular audits that were previously expected to be carried out, that included environmental radiation monitoring, quality control measures of radiological equipment, and personnel radiation dose monitoring. However, as these were not being undertaken, the service was unable to gather information that would help improve service delivery and patient care.

The service provided evidence of bespoke audits carried out to evaluate service delivery and identify areas for improvement. For example, the service provided an audit of lead protective equipment used in the Radiology Department (as recommended by the Royal College of Radiologists).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The trust provided evidence of the local induction process for each modality. This included information on lead staff, useful contact numbers, shift patterns, and local rules.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff also had a monthly one to one with managers as part of their supervision which included discussions on personal development.

Staff stated they felt supported in their professional development. Staff stated that they had been encouraged to develop their skills and progress in their careers with the Radiology Department. Managers stated that supporting staff to develop their skills allowed them to retain the staff they had. For example, the Radiology Department had trained radiography staff to be able to interpret and report on the diagnostic images.

The practice educators supported the learning and development needs of staff. Staff had access to practice educators and that they provided advice and support in regard to training if needed. The department was also providing an increase in the number provision of practice educators to meet the needs of the new Imaging Academy.

The Imaging Academy had a training structure in place to provide undergraduate and postgraduate education to staff across all imaging modalities, as well as stand-alone course and simulation training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We requested records from clinical and operational Radiology meetings and found they had been minuted.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Diagnostic imaging

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held operational and clinical governance meetings to discuss service delivery and any issues of quality and safety were escalated appropriately. We observed meetings being minuted to record actions for follow up. Staff also held daily huddles to discuss patients and improve the delivery of care.

Staff were positive about the working relationships between staff disciplines and different modalities. Staff stated they felt well supported by managers and by colleagues, and that there was a well-developed atmosphere of teamworking. Patients we spoke with stated that they felt staff worked well together.

Seven-day services

Key services were available to support timely patient care.

Diagnostic imaging operated 24 hours a day, seven days a week service. This included access for emergency referrals for imaging through the appropriate process. Between 9am and 5pm Monday to Friday imaging results were reviewed by the Duty radiologists. Radiologist on-call cover was available 5pm to 8pm weekdays and 8am to 6pm weekends.

Outside of these hours there was access to a teleradiology provider between 5pm to 8am for the Emergency Department, and 8pm to 8am for inpatients on weekdays.

After the inspection we reviewed the standard operating procedure for radiology access at King George Hospital in and out of hours, and found it reflected the practice we found on inspection.

Health promotion

Staff gave patients practical support and advice to lead healthier lives, however we did not consistently observe patient information leaflets or posters in patient areas.

On inspection we did not observe relevant information on promoting healthy lifestyles and support in patient areas. More information on this issue can be found in the Responsive section under the KLOE for Meeting People's Individual Needs.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff we spoke with demonstrated sufficient understanding of their responsibilities in regard to consent.

Diagnostic imaging

Staff clearly recorded consent in the patients' records. We saw evidence that consent had been recorded in line with legislation. We also viewed patient information leaflets on diagnostic imaging that provided more detail about procedures ahead of the patient giving consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance. Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had a consent policy which was in date and was compliant with the Mental Capacity Act and Deprivation of Liberty Safeguards legislation. The policy set out staff responsibilities for seeking and obtaining informed consent, including the type of consent (verbal or written) needed for procedures undertaken.

Is the service caring?

Good 

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We spoke with four patients and a family member who stated staff were very friendly, kind, and considerate throughout their treatment. Some diagnostic imaging areas provided evidence of patient feedback through thank you cards in communal areas.

Staff followed policy to keep patient care and treatment confidential. Each imaging area had a dedicated waiting area for patients and visitors, and we observed staff being discrete when calling patients in for appointments.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients said their individual needs had been well met and that the care they received was patient centred.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with felt they had been well supported throughout their treatment and felt able to ask questions as and when they needed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Diagnostic imaging

While the radiology department did not have dedicated access to psychological support, the trust provided information on available support through specialities following inspection. This included information on access for cancer patients receiving treatment to Clinical Nurse Specialists and the Living with and Beyond Cancer Team (LWBC). If psychological concerns were identified the LWBC could support referral to the Cancer Psychology Team. Ultrasound patients would also be able to access psychological support through the antenatal mental health service.

The radiology department could access the multi-faith chaplaincy service which could provide pastoral and religious support for patients, as well as access to religious materials. The hospital also had support for information and advice regarding bereavement.

We saw evidence of study days organised to support staff having difficult conversations with patients and families. For example, sonographers had access to training in bereavement support for mothers following the loss of a child.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us they were given clear information regarding the benefits and risks related to their appointment and were given the opportunity to ask questions. This meant staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. The trust collected patient feedback using a patient satisfaction survey company who compiled the results. The trust could access compiled reports on patient feedback and use them to review patient experience and make changes to service delivery. The number of patients providing feedback for radiology at King George Hospital using this survey was low, as patients related the imaging department with their experience of other specialities. However, between August 2021 and August 2022, the average monthly patient experience score was between 4.14 and 5 (out of five stars).

The trust also reviewed comments from patients on the NHS Choices website and responded to address any highlighted concerns or offer patients further support. This included signposting patients to trust services if needed.

The trust provided reports on visits to the radiology department by members of their Patient Partnership Council (PPC) between November 2021 and October 2022. The PPC is a patient and public involvement forum, including both lay members and staff, which aims to improve the quality and safety of the care delivered. The reports provided detailed areas of feedback for lay members who visited the radiology department and gave feedback on the care and practice they observed. They also spoke with patients and reported this. The reports we reviewed were generally positive about the experience of patients using the service, and where possible improvements were identified this was recorded to be actioned.

Comments and feedback from the patients were used to improve the service. We saw evidence that patient satisfaction and comments were reviewed in the clinical and operational meetings, as well as in the PPC, and recommendations from feedback put into practice.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff stated they could access translation services if needed and provide information in languages other than English.

Diagnostic imaging

Patient information leaflets stated that patients could request or be allocated a chaperone for some diagnostic modalities. Information on Chaperones in radiology was also available on the trust website.

Is the service responsive?

Requires Improvement



Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The radiology department operated an appointment-based service for imaging through GP referral. There were also clear pathways for ad-hoc scanning for inpatients, the emergency department, and outpatients available as needed by referral.

In the last twelve months the Radiology Department had seen 571,798 patients, with the largest percentage of total established patients being Accident and Emergency (18%). The main radiology areas for the hospital were located opposite the Emergency Department which provided ease of access, and there was dedicated imaging equipment and allocated time to meet the needs of urgent care.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Radiology had clear pathways in place to ensure the process was efficient for patients.

The radiology department had a centralised booking team for organising appointments for diagnostic imaging. Patients would be informed of appointments by letter and would receive a reminder closer to the appointment date.

Facilities and premises were appropriate for the services being delivered. All radiology areas were located on the ground floor and were well signposted. The service had adequate number of imaging rooms and communal reception areas with adequate seating. Patients told us they were happy with the location of the hospital, they found it easily accessible with good parking facilities.

The service had systems to help care for patients in need of additional support or specialist intervention. Imaging specialities could risk assess patients to establish if any additional support was needed and also offered tailored services for patient groups with specific risk factors. For example, the department provided a radiographer-led CT Colonoscopy service for patients risk assessed as frail.

The service relieved pressure on other departments when they could treat patients in a day. Radiology had dedicated time and equipment for meeting the needs of the Emergency Department, which allowed them priority access to getting diagnostic imaging results.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the service did not consistently provide patient information leaflets and posters.

Diagnostic imaging

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff stated they could also contact the trust Dementia and Delirium team to support care for patients with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust was able to provide information in an accessible format for people with sensory loss in line with the NHS Accessible Information Standard. Staff in the radiology department stated they could also access the learning disabilities and autism team when working with patients with learning disabilities. The trust provided access to the hospital passport, which helped patients with learning disabilities communicate their anxieties, likes and dislikes to staff.

The service did not have information leaflets or posters consistently displayed in communal waiting areas for diagnostic imaging. We observed patient information leaflets in use to be given to some patients as part of appointments in some areas of radiology, however this was also inconsistently applied. The use of patient information leaflets and posters was not curated within the Radiology Department, and often there was little guidance on trust services or public information. This was particularly the case in the communal areas for X-ray and the refurbished MRI area.

Managers made sure staff, and patients, loved ones and carers could, get help from interpreters or signers when needed. The service stated that information leaflets could be made available in languages spoken by the patients and local community. Interpreters were also available face-to-face if needed to translate for patients. Many staff members spoke languages other than English and could provide some translation to improve the patient experience and understanding.

The hospital had a multi-faith prayer room that was open 24-hours a day, as well as a multi-faith chaplaincy service with links to local faith communities.

Access and flow

People could access the service when they needed it and received the right care. Waiting times for treatment were in line with national standards.

Managers monitored waiting times; however, the Radiology Department was currently investigating a Serious Incident related to inaccurate data in the trust's patient tracking list (DM01). This meant at the time of inspection the trust could not provide assurance on the accuracy of patient waiting times or the impact of the data inaccuracy on patients. More information on this issue can be found in the Well Led section under the Key Line of Enquiry (KLOE) for Information Management.

Following the trust review of the accuracy of the Patient Waiting List (PTL) in August 2022, the number of patients awaiting an appointment for diagnostic imaging was 13,226. The modalities experiencing the longest wait times were in MRI and ultrasound. MRI and ultrasound were also the modalities most significantly impacted by the serious incident affecting the accuracy of the PTL.

Radiology managers made sure patients could access emergency services when needed. The Radiology Department had a dedicated pathway for Emergency Department (ED) patients who required a diagnostic scan. Unlike other in-hospital pathways the ED pathway did not require a radiologist referral. Radiology also had dedicated emergency imaging equipment and staff allocations to ensure emergency patients were seen as quickly as possible.

Managers monitored and took action to minimise missed appointments. The trust encouraged patients through information leaflets and the website to inform the service if they could not make appointments or if they no longer

Diagnostic imaging

needed the appointment anymore. The numbers of patients who Did Not Attend (DNAs) or cancelled appointments without sufficient notice were reviewed as part of quality and performance meetings to identify themes and take action. Patient information documents also stated that patients who did not attend appointments may be discharged from the hospital's care.

The trust provided information on Did Not Attends (DNAs) and cancellations for the Radiology Department in the past twelve months. Between November 2021 and November 2022, the cancellation rate was between 8% and 13% across all specialities with the highest figures for MRI (13%) and CT (10%). The DNA rate for the same period ranged between 2% and 8%, with the highest DNAs in ultrasound (8%) and obstetric ultrasound (7%). This was higher than the England average of 4.7%.

Managers monitored the performance of the emergency pathway into diagnostic imaging. The trust had an internal target of one-hour from when an ED CT request was made to the scan being carried out, and a further one-hour target to receive a report from that scan. The trust monitored performance in relation to this target between May and July 22 and found 80% of scans were completed, with the report available, within one hour.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

It was generally easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients knew how to complain or raise concerns. Patients we spoke to stated they were confident they could raise a complaint to the radiology department and that it would be taken seriously.

Information on how to complain was available on the trust website. However, the service did not clearly display information about how to raise a concern in patient areas and communal areas did not consistently display patient information leaflets and posters throughout the radiology department.

The trust had a system for handling complaints and concerns. Staff understood the policy on complaints and followed the organisation's complaints policy. We reviewed this policy and process and found it to be in date and in line with national guidance.

Managers investigated complaints and identified themes. Service leads led on investigating complaints, supported by clinicians where there was the need for clinical input and depending on the nature of the complaint. We reviewed the Divisional Quality and Safety Group minutes following inspection and found complaints and investigations were discussed in these meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were acknowledged within three working days and the trust had a regular normal resolution timescale of ten working days (which could be extended in agreement with the enquirer). Performance against this standard and updates on significant complaint investigations was monitored in divisional meetings.

Diagnostic imaging

Managers shared feedback from complaints with staff and learning was used to improve the service. In the last twelve months the trust reported 39 formal complaints lodged for the Radiology Department. We reviewed examples of recent resolved complaints for Radiology which evidenced the Department reviewing and altering service delivery to address the concerns raised in the complaints.

The trust provided information collected by the PALS team in regard to the Radiology Department, which included thematic review of the reasons they had been contacted. Most PALS contacts in regard to diagnostic imaging related to appointment queries, such as confirming a date of appointment or ensuring accuracy of appointment information.

Is the service well-led?

Requires Improvement ●

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Radiology Department at King George Hospital was part of the Cancer and Clinical Support Division. The department was led by a triumvirate: a Clinical Lead with oversight for Reporting Radiologists, a Specialty Manager with oversight for operational and business functions, and a Professional Lead with oversight for radiographers and imaging leads.

Staff we spoke with talked positively about the leadership and managers of the service department. Frontline staff said the leadership and service leads were supportive and invested in developing their staff. Staff also stated that service leaders were visible around the service and were approachable if staff needed anything.

There was a clear leadership structure in place. Staff knew their reporting responsibilities and who issues needed to be escalated to. Staff stated they felt comfortable bringing issues to their managers and felt they would be taken seriously.

The service was committed to developing their own leaders. Staff informed us of support they had from the organisation to develop and take on managerial roles. Staff stated there were more opportunities to do this at King George Hospital because many of the staff lived locally and wanted to progress there.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear strategic vision and business plan to continue the programme of refreshing equipment and the radiology department environment in 2021 and 2022. The service had a clear strategic vision which included a long-term plan to align all diagnostic services under one “umbrella” across all of Barking and Dagenham, Havering, and Redbridge.

Diagnostic imaging

This community district hub would have satellite diagnostic services at locations such as Barking Community Hospital, with the main “hub” to be located eventually at King George Hospital. The plan aligned to NHS England’s long-term plan for community diagnostic hubs. The strategy included a business plan to continue on the programme of refreshing equipment and the radiology department environment that had commenced in 2021 and 2022.

Staff were aware of the plans to develop King George Hospital into a community diagnostic hub and felt they had been well informed on progress and changes. We saw evidence of staff being consulted on the strategic direction and engaged in the process by regular updates and opportunities to feedback.

The trust engaged on the strategic direction for diagnostic imaging with other stakeholders in the North East London Integrated Care Systems (ICS). This included considering where there were opportunities for working together and sharing resources across the region. For example, BHRUT were working with other acute trusts to establish if they could share a diagnostic image management platform. This would allow diagnostic results to be shared across all North East London (NEL) NHS acute trusts as part of a provider collaborative.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said they felt supported, respected and valued. Staff consistently told us they were proud to work for the service and enjoyed their work. There was a strong emphasis on the safety and well-being of staff; for example, the provider had considered the management of staff wellbeing after the COVID pandemic, and there was individual psychological support available to staff (called “Listen Hear”) as well as team support (called “Let It Out”). All staff also had access to the organisational development team for support and advice.

Staff worked in collaborative and cooperative teams. The Radiology Department had a culture which was centred on the needs and experience of people who use the services and had robust mechanisms to gain patient feedback and improve services as a result.

The staff culture encouraged openness and honesty within the Radiology Department, including with people who use services, in response to incidents and complaints. Staff were supported to raise concerns and stated that they felt they would be listened to. The service also had a whistleblowing policy which outlined how staff could speak up, and a freedom to speak up guardian which staff could access.

The Radiology Department had mechanisms for providing staff with opportunities for career development. For example, staff stated that managers encouraged them to consider their career development. Where staff had development plans from their appraisals, managers encouraged and supported staff to achieve their goals. Staff we spoke with were positive regarding the opportunities to develop and learn within their roles.

The trust carried out staff surveys to get feedback from the diagnostic imaging workforce. The trust provided results from the most recent staff survey from the Cancer and Clinical Support Services Division. The questions were separated into categories including job satisfaction, relationships between managers and teams, personal development, and wellbeing. The Radiology Department provided results from the 2022 survey, with results varying across modalities. Ultrasound and Fluoroscopy performed generally better than the departmental average, while Plain Film and MRI were below the departmental average.

Diagnostic imaging

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had effective levels of governance and management structures that interacted with each other. At a departmental level Radiology had the monthly radiology events and learning meetings (REALMs), a process developed by the Royal College of Radiologists, which reviewed performance and clinical governance. The Department also had weekly operations meetings in each area and daily team huddles each morning.

Staff stated that monthly REALMs included review of incidents, consideration of risks in the Department, sharing learning from incident investigations, and any discrepancies for consideration. We reviewed examples of minutes from REALMs and found they included clear consideration of clinical risks to the Department.

Concerns from REALMS and operations meeting were escalated to the monthly Cancer and Clinical Support Divisional Quality and Safety Meeting, or the Divisional Business Meeting. We reviewed minutes from both meetings after inspection. The meetings included an action log to follow up on any agreed actions and demonstrated oversight of the Radiology Department.

The Radiology Department had governance arrangements in place with the third-party organisations that provided the Teleradiology service and the Radiology Information System (RIS). We reviewed the service level agreements (SLA) in place. Each SLA outlined that the third-party providers must complete and publish an annual information governance assessment using the NHS information governance toolkit, achieve a minimum level 2 performance against all requirements in the relevant NHS information governance toolkit, and nominate an information governance lead. The SLAs also required the third-party organisations report any information governance concerns immediately.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Diagnostic imaging had assurance systems in place to monitor safety performance. Risks were regularly discussed and reviewed in team meetings. We reviewed risks being considered in Radiology Departmental REALMS and divisionally in the Cancer and Clinical Support Divisional Quality and Safety Meeting.

Managers and clinical leads monitored performance through both operational and clinical governance meetings. Managers stated that if results fell below expectations the department developed plans to address the issues and the learning and actions were shared with the team through team meetings, huddles, and other staff engagement.

Diagnostic imaging had arrangements for identifying, recording and managing risks to service delivery. The Radiology Department had operational meetings which included regular discussion of the risk register. Following inspection, we reviewed the risk register scores from the October 2022 REALM. The risk register identified the top risk as the “reporting backlog for scans undertaken in CT, MRI and Plain Film”. The departmental response to this risk is covered in the Information Management section. We found there was alignment between the recorded risks and what staff identified as the main issues on inspection.

Diagnostic imaging

Information Management

The service had not collected reliable data in regard to patient waiting times. Issues in the scripts of the information systems had resulted in inaccurate data which may have prolonged waiting times for patients. While data was being submitted to external organisations as required, the data was not accurate and a data validation exercise was underway to address the incident.

In August 2022 the trust declared a Serious Incident in relation to the accuracy of their patient tracking list (PTL) and activity data for diagnostic imaging patients. This list, referred to as the DM01, shows the order of priority for patients awaiting a radiology scan and tracks acute trusts' performance against a standard of six weeks for a diagnostic test.

The trust had switched to a new Radiology Information System (RIS) in October 2021 and had reviewed the script of the RIS to check if changing to a new system would still allow accurate collection of the DM01 data. However, in July 2022 the trust reported that the script for the RIS had excluded a significant number of patients from the PTL. This occurred for any patient that did not have a clinical speciality selected in the referral process by the referring person. When the error was rectified and patients were added, this meant that the DM01 list went from 4,883 on 25th July 2022 to 13,226 on 8th August 2022, an increase of 8,343 patients. This meant that patients who should have been on the PTL awaiting an appointment for diagnostic imaging had not been.

After identifying the 8,343 patients the trust carried out a validation exercise to confirm the accuracy of the increase in patients waiting. This exercise resulted in 2,017 patients being removed from the waiting list as being already investigated or no longer needed investigation. This reduced the number of patients affected to 6,326. Further validation then subsequently decreased this number to around 4,000 patients.

At the time of our inspection, the trust had committed to clinical harm reviews to establish if there had been any adverse impact to patients, and carried out a data validation exercise which included contacting all patients currently waiting over six weeks. The trust also commenced a serious incident working group to meet regularly and accelerate the response to the incident. However meeting minutes for this group from November 2022 showed that the clinical harm review had still not been started by November, and that this delay need to be addressed immediately.

It was not clear at the time of inspection or at the time of this report (December 2022) what the full outcome of any clinical harm review was, either in relation to the extent of the harm or the number of people impacted. As part of the incident investigation the trust reviewed a sample of 100 patient scans, which represented just over 2% of the patients affected by the incident. The sample was drawn from patients who had waited the longest with reported scans. The available harm review stated of the 100 scans reviewed "28 showed significant findings i.e. new diagnoses or progressions of a previous diagnosis", and that "out of the 28 positive findings the clinicians agreed that were scenarios where a delay in diagnosis had the possibility to affect prognosis. The trust stated that there would be a review of a further 100 patients to improve the trust's oversight of the impact to patients.

To address the increased volume of appointments, the trust put in place actions to reduce the backlog of patients waiting and to recover a compliant DM01 position. This included additional weekend clinics and extended hours in ultrasound, computerised tomography (CT), and magnetic resonance imaging (MRI), outsourcing patients to local private providers, and obtaining mobile CT and MRI scanners to increase capacity. The trust stated that the expectation for returning to a DM01 compliant position was between December 2022 and January 2023 depending on speciality and modality, while there is an expectation from NHSE that the trust were 95% compliant by March 2023.

Diagnostic imaging

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Radiology Department provided staff information through emails, in team meetings, and through other means of staff engagement. This included feedback from patients, information on areas for learning based on reviews of performance, risks identified for the service, staff acknowledgements and awards, and other areas of quality and performance.

The trust collected patient satisfaction information using a patient satisfaction survey company. Results were available to be review and discussed at team meetings, and service delivery was adjusted to improve service delivery for patients.

The Radiology vision and strategy outlined some of the engagement activities the department had undertaken recently. This included improvement and engagement sessions for staff, quarterly staff briefings, and a “you said, we did” process for staff. Engagement also included radiology managers engaging with the trade union and professional body for radiographers.

The Radiology Department had engaged staff members as The Workforce Race Equality Standard (WRES) champions. The NHS WRES was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Managers in the Radiology Department stated that they produced a regular staff newsletter to provide information to staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Radiology Department had recently opened the NEL Imaging Academy based at King George Hospital in partnership with Health Education England (HEE). This aimed to provide training and education (including simulation training) for the NEL diagnostic imaging workforce across a range of specialties in a newly designed bespoke centre. At the time of inspection, the Radiology Department had planned the governance structure, had advertisements in place for Practice Education Leads, and had agreed priorities and objectives up to 2025. The Imaging academy also had a steering group which included representatives from acute trusts across NEL, North East London ICS, and NHS England.