Barking, Havering and Redbridge University Hospitals NHS Trust

King George Hospital

Quality Report

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

Ratings

Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Barking, Havering and Redbridge University Hospitals NHS Trust provides acute services across three local authorities: Barking & Dagenham, Havering and Redbridge. Serving a population of around 750,000 and employing around 6,500 staff and volunteers.

King George Hospital opened at its current site in Ilford in 1995 and provides acute and rehabilitation services for residents across Redbridge, Barking & Dagenham, and Havering, as well as providing some services to patients from South West Essex. The hospital has approximately 450 beds.

The trust was previously inspected in 2013, and due to concerns around the quality of patient care and the ability of the leadership team, the Trust Development Authority (TDA) recommended that the trust be placed in special measures.

We returned to inspect the trust in March 2015. A new executive team had been appointed, including a new Chair. Overall, we found that improvements had been made, however it was evident that more needed to be done to ensure that the trust could deliver safe, quality care across all core services.

The trust has continued its improvement plan, working closely with stakeholders and external organisations. On this occasion we returned to inspect the trust in September and October 2016, to review the progress of the improvements that had been implemented, to apply ratings, and also to make recommendation on the status of special measures. We carried out a focused, unannounced inspection at King George Hospital of three core services – the Emergency Department (ED), Medical Care (including older people's care) and Outpatients & Diagnostics (OPD).

This inspection subsequently found that some improvements had been made and ratings have been adjusted accordingly. Overall, we have rated King George Hospital as requires improvement.

Our key findings were as follows:

Are services safe?

- The percentage of patients seen on arrival in the emergency department (ED) within 15 minutes between August 2015 and August 2016 averaged 70%.
- There was a lack of evidence that learning and understanding of treating patients with suspected sepsis was embedded within the ED.
- Patient records were not always kept secure.
- There was a high dependency on locum doctors and lack of senior medical staff in the ED.
- There were too few paediatric nurses in the ED.
- There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services.
- Medical staff were failing to meet trust targets for completion of mandatory training, across all topics.
- Staff completion rates in basic life support were below the trust target, due to a lack of external training sessions. There were low levels of resuscitation training in the ED.
- There were poor levels of hand hygiene compliance observed in the ED and in OPD.
- Although a comprehensive induction programme was in place for all new diagnostic imaging staff, some new staff members did not know where to find the Local Rules.
- The air handling unit in paediatrics and minor injuries had been out of service for at least three weeks prior to this inspection.
- There had been an improvement in the reporting of incidents and the sharing of lessons from these across the hospital.
- Staff were aware of their responsibilities with regards to duty of candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan.

Summary of findings

- The dispensing and administration of medication had improved, with prescription charts being used correctly and processes being correctly followed and audited. Medication in the emergency and OPD were found to be appropriately stored.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.

Are services effective?

- There was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- Fluid charts were not always filled out and some patients did not like the food, or found it hard to eat.
- Patient outcomes in care of the elderly were limited by the lack of consultant geriatricians to lead improvements within the service.
- In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures.
- The pathways for patients with cancer were not always correctly managed. There was poor communication with tertiary centres, which caused delays with patients requiring tertiary treatment/diagnosis at other specialist hospitals.
- There was a lack of effective seven day working across the hospital.
- The trust had updated all of their local policies since the last inspection, and these were regularly reviewed.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement.
- Pain was assessed and well managed on the wards, with appropriate actions taken in response to pain triggers. There was a dedicated hospital pain team.
- The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals.
- There was evidence of effective multidisciplinary working within wards and across departments. All members of staff felt valued and respected.
- Patients attending OPD received care and treatment that was evidence based.

Are services caring?

- Patients were cared for in a caring and compassionate manner by staff throughout their stay. Most medical wards performed in line with the national average in the NHS Friends and Family Test (FFT).
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Psychological support for patients was easily accessible and timely. Patients were routinely assessed for anxiety and depression on admission.
- The chaplaincy team offered comprehensive spiritual support to all patients, regardless of religious affiliation.
- Some patients and relatives felt that more could be done to involve them in their care, especially surrounding discharge.

Are services responsive?

- The ED failed to meet the four hour national indicator for treating or admitting patients.
- There was no viewing room in the ED where people could see their deceased relatives.
- The trust was consistently failing to meet national indicators relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance.
- The trust was not meeting 18-week national indicators for non-urgent referral to treatment (RTT) times.
- The percentage of patients who did not attend (DNA) their appointment was above the England average.
- 13% of appointments were cancelled by the hospital. This was higher than the England average of 7.2%.
- NHS England suspended endoscopy screening invitations to the trust for eight weeks from July 2016. There was a risk of delayed diagnosis of bowel cancer due to inability to provide a full screening service to the local population.

Summary of findings

- Staff across the hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place.
- Patient information leaflets were not standardly available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
- Diagnostic waiting time indicators were met by the trust every month between May and August 2016, meaning over 99% of patients waited less than six weeks for a diagnostic test.
- There had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016.The hospital was using a range of private providers to assist in clearing the backlog of appointments where there were most demand for services.
- Ward-based pharmacists helped to facilitate discharges in areas where they were available. There was also a pharmacy discharge team who worked 11am to 4pm weekdays.
- Walk-in patients were streamed effectively in the ED, including back to their own GP.
- People living with dementia received tailored care and treatment. Care of the elderly wards had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help. Patients living with dementia were nursed according to a specially designed care pathway and were offered 1:1 nursing care from healthcare assistants with enhanced training. A specialist dementia team and dementia link nurses were available for support and advice. There were also dementia champion nurses in the ED.
- Support for people with learning disabilities was available. There was a lead nurse available for support and advice.
- There was a frail and older person's advice and liaison team which worked closely with the ED.
- The environment of children's ED was child friendly and well laid out.

Are services well led?

- The trust had developed a clinical vision and strategy and communicated this to staff of all levels across the hospital.
- There was a system of governance and risk management meetings at both departmental and divisional levels across core services, however this had not yet developed effectively in some areas at the time of inspection. An external organisation had worked with the trust on ensuring their governance structures were more robust.
- Quality improvement and research projects took place that drove innovation and improved the patient experience. Regular audits were undertaken, overseen by a committee. The hospital facilitated a number of forums and listening events to engage patients in the development of the service.
- Most nursing and medical staff thought that their line managers and the senior team were supportive and approachable. The chief executive and divisional leads held regular meetings to facilitate staff engagement. However, some comments we received from staff reflected that they were not always happy with the management or leadership.
- The trust could not evidence how they maintained records to ensure they knew their locum staff had up to date training in sepsis management
- Many staff with whom we spoke were unclear about the future direction of the ED and the impact on job security.
- Monthly nurse staff meetings in the ED had become less frequent due to pressures of work.

We saw several areas of outstanding practice including:

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to make their stay in hospital easier and reduce any emotional distress.

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

Importantly, the trust must:

- Ensure all patients attending the ED are seen more quickly by a clinician.

Summary of findings

- Take action to improve levels of resuscitation training.
- Ensure there is oversight of all training done by locums.
- Take action to improve the response to patients with suspected sepsis.
- Take action to address the poor levels of hand hygiene compliance in ED.

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Increase paediatric nursing capacity.
- Ensure there is a sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure that all policies are up to date.
- Improve appraisal rates for nursing and medical staff.
- Ensure that consent is clearly recorded on patient records.
- Regularise play specialist provision in paediatric ED.
- Ensure that patient records are stored securely.
- Ensure staff and public are kept informed about future plans for the ED at King George hospital.
- Continue plan to repair breaches in the fire compartmentation as detailed on the corporate risk register.
- Continue to monitor hand hygiene and infection control across all medical wards and follow action plans detailed on the current corporate and divisional risk registers.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.
- Make patient information leaflets readily available to those whose first language is not English.
- Increase staff awareness of the availability of interpretation services.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure there is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.
- Ensure the 18 week waiting time indicator is met in the OPD.
- Ensure the 52 week waiting time indicator is consistently met in the OPD.
- Ensure the OPD 62 day cancer waiting time is consistently above 85%.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.

Summary of findings

- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Lack of resuscitation training was rated as high on the corporate risk register and compliance rates for resuscitation training were low for both doctors and nurses. No paediatric staff grade nurse had in-date advanced paediatric life support training. Whilst the trust told us it confirmed all training done by locum staff on their induction checklist, it was unable to supply CQC with a record of all training done by locum staff, including resuscitation, sepsis and safeguarding training. There was poor recognition of and response to patients with suspected sepsis. There were poor levels of hand hygiene compliance. The air handling unit in paediatrics and minor injuries had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs. There was a 59% vacancy rate amongst medical staff and the lack of senior medical staff was rated as high on the corporate risk register. This resulted in a high dependency on the use of locum staff, who whilst fully qualified as doctors may not have worked in an emergency department previously. In addition, there was a shortage of paediatric nurses which was also rated as high on the corporate risk register. The ED failure to comply with the four hour standard was rated as extreme on the corporate risk register. Ambulance turnaround time did not meet the national handover indicator for 64% of the time between June 2015 and May 2016. However, staff told us that they were encouraged to record incidents and said there was good sharing of learning from incidents through e-mail, meetings and training days. Junior doctors felt well supported by senior doctors. Walk-in patients were effectively streamed and some were redirected back to their GP.

Summary of findings

Staff were compassionate towards patients and there was a frail and older persons advice and liaison team as well as dementia champion nurses in the ED.
There was a designated observation ward which was used to assess the community support needs of vulnerable patients before being discharged.
Patients told us they felt staff informed them of what was going on and staff told us they knew who the departmental leadership team and the executive board were.
Since the last inspection in May 2015 improvements had been made to the department's clinical governance and risk management processes.

Medical care (including older people's care)

Requires improvement

Hospital environments were not always ideal. Some wards were reported and observed to have high levels of noise and heat. There was a lack of bedside televisions or radios across the wards. There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services.
Although we observed good infection control practices on inspection, rates of both MRSA and Clostridium difficile infections were high. Infection prevention and control audits, as well as hand hygiene audit results, showed consistently poor compliance in some wards and departments.
Although nursing staffing levels had improved since our last inspection in March 2015, some wards still had significant vacancy and turnover rates. On these wards, there was a reliance on bank and agency staff to fill vacant shifts.
There was a reliance on locum doctors across the service, apart from in cardiology. This affected continuity of patient care, particularly out-of-hours.
Medical staff across the service were failing to meet trust targets for completion of mandatory training.
For non-elective admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine. Patient outcomes in care of the elderly were limited by the lack of consultant geriatricians to lead improvements within the service. Junior doctors in geriatric medicine reported lower overall satisfaction than the national average in the 2015 National Training Survey. There

Summary of findings

was also poor performance in measures such as availability of clinical supervision out-of-hours and regional teaching. Although 2016 survey results showed significant improvement, some issues still remained.

Medical and nursing staff completion rates in basic life support were below the trust target, due to a lack of external training sessions.

There was still a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust. The trust performed worse than the previous year in a number of national audits.

Some principles of good record keeping were not being followed. Fluid charts were not always filled out and medical entries were sometimes illegible and unsigned.

The pathology service was understaffed and unable to provide effective cover out-of-hours.

The pathways for patients with cancer were not always clear. The trust was consistently failing to meet national indicators relating to 62-day cancer treatment. There was poor communication with tertiary centres, which caused delays with patients requiring tertiary treatment or diagnosis at other specialist hospitals. The trust performed slightly below the national average in the National Cancer Inpatient survey 2015.

The trust was not meeting 18-week national indicators for non-urgent referral to treatment (RTT) times.

Staff across the hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place. Some patients and relatives felt that more could be done to involve them in their care, especially surrounding discharge.

Patients were not always able to be located on the specialist ward appropriate for their condition, although management of these patients had improved since the previous inspection. The number of patients moved four or more times per admission had increased, although the trust later told us that this data was inaccurate. In some wards, such as Ash, Gentian and Gardenia ward, bed moves were consistently occurring out of hours (between 10pm and 6am).

Summary of findings

Patient information leaflets were not standardly available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner. There were no leaflets detailing how to access PALS and make a formal complaint on Gentian ward at the time of our inspection.
However, there was a significant improvement in both the reporting of incidents and the sharing of lessons learned from these across the hospital. Staff were aware of their responsibilities with regards to duty of candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan. The governance structure had been revised to provide a greater level of accountability and oversight of risk.
Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. They knew how to escalate concerns and were up-to-date with appropriate levels of training.
Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools.
Medicines management had improved, with new processes in place to ensure the safety of patients. Much work had been done since the previous inspection to ensure that discharges were not delayed due to unavailability of take home medications.
Nursing and medical staff completed a variety of local audits to monitor compliance and drive quality improvement. Staff told us that these led to meaningful change across the service. Both local and national audits were overseen by a committee.
In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant

Summary of findings

that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate.

Patients were cared for in a caring and compassionate manner by staff throughout their hospital stay. Most medical wards performed in line with the national average in the NHS Friends and Family Test (FFT). Patients' privacy and dignity was maintained at all times. The hospital facilitated a number of forums and listening events to engage patients in the development of the service.

The trust performed above the national average in measures relating to training and appraisals in the NHS staff survey 2015. The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals. The trust was supporting nurses with the revalidation process. For all specialties apart from geriatric medicine, the trust scored above the national average for most measures in relation to first year medical doctors in training (2015 National Training Survey).

There was evidence of effective multidisciplinary working within wards and across departments. All members of staff felt valued and respected by their colleagues.

Psychological support for patients was easily accessible and timely. Patients were routinely assessed for anxiety and depression on admission. The chaplaincy team offered comprehensive spiritual support to all patients, regardless of religious affiliation.

People with complex needs, such as those living with dementia or a learning disability, were well considered and cared for within the hospital. Staff made reasonable adjustments to improve their experience of the service and supported them throughout their inpatient stay. Information and environments had been adapted to make them more suitable for these patients.

The trust had developed a clinical vision and strategy and communicated this to staff of all levels, enabling them to feel involved in the development of the service. Most nursing and medical staff

thought that their line managers and the senior team were supportive and approachable. The chief executive and divisional leads held regular meetings to facilitate staff engagement.
Staff had awareness of what actions they would take in the event of a major incident, including a fire. Regular drills were held to ensure staff were adequately trained in the event of emergencies.

Outpatients and diagnostic imaging

Requires improvement

Outpatients and diagnostic imaging services were in transition. The strategy for these services was in development. There were a number of new senior managers who had introduced new quality assurance and risk measurement systems. However, these were not fully embedded.
Hand gel dispensers were in situ across outpatients and diagnostic imaging but we did not observe staff or patients using them.
The percentage of patients who did not attend (DNA) their appointment was above the England average.
Staff told us they were not confident of meeting the national indicator for patients waiting over 18 weeks by their target date of March 2017. The trust's performance for the 62 day cancer waiting time was consistently below the England average.
Appointments cancelled by the hospital were also higher than the England average.
Some staff in the diagnostics and imaging team said there was a lack of clarity around their roles and responsibilities.
However, there had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016.
Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. Lessons were learnt from incidents and shared across the trust.
The trust had changed their patient records system and introduced the electronic patient record (EPR).
There were appropriate protocols in place for safeguarding vulnerable adults and children. Staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.
Patients' and staff views were actively sought and there was evidence of improvement and development of staff and services. Staffing levels and skill mix were planned to ensure the delivery of

Summary of findings

outpatient, diagnostic and imaging services at all times. All new staff completed a corporate and local induction. . Staff were competent to perform their roles and took part in benchmarking and accreditation schemes.

Medicines were found to be in date and stored securely in locked cupboards. Staff were able to describe the procedure if a patient became unwell in their department and knew how to locate the major incident policy on the intranet.

All the patients, relatives and carers we spoke with were positive about the way staff treated people. There was a visible person-centred culture in most departments. Patients and relatives told us they were involved in decision making about their care and treatment. People's individual preferences and needs were reflected in how care was delivered.

Work was in progress to conduct a demand and capacity analysis to enable the service to develop a model whereby the hospital could assess and effectively manage the demands on the service. The hospital was using a range of private providers to assist in clearing the backlog of appointments.

Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based. The service was monitoring the care and treatment outcomes of patients who were receiving outsourced care from providers in the private sector.

Outpatients, diagnostic and imaging services had introduced extended clinics seven days a week to clear patient waiting list backlogs.

There was a formal complaints process for people to use. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms.

Most local managers demonstrated good leadership within their department. Managers had knowledge of performance in their areas of responsibility and understood the risks and challenges to the service. There was a system of governance and risk management meetings at both departmental and divisional levels.

King George Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to King George Hospital

King George Hospital opened at its current site in Ilford in 1995 and provides acute and rehabilitation services for residents across Redbridge, Barking & Dagenham, and Havering, as well as providing some services to patients from South West Essex. The hospital has approximately 450 beds.

The trust was previously inspected in 2013, and due to concerns around the quality of patient care and the ability of the leadership team, the Trust Development Authority (TDA) recommended that the trust be placed in special measures.

We returned to inspect the trust in March 2015. A new executive team had been appointed, including a new Chair. Overall, we found that improvements had been made, however it was evident that more needed to be done to ensure that the trust could deliver safe, quality care across all core services.

On this occasion we returned to inspect the trust in September and October 2016, to review the progress of the improvements that had been implemented, to apply ratings, and also to make recommendation on the status of special measures.

We carried out a focused, unannounced inspection at King George Hospital of the Emergency Department (ED), Medical Care and Outpatients & Diagnostics (OPD).

Our inspection team

Our inspection team was lead by:

Head of Hospital Inspection: Nicola Wise, Care Quality Commission (CQC)

Inspection Managers: Max Geraghty (CQC), David Harris (CQC), Robert Throw (CQC)

The team included CQC Inspectors, analysts, planners and a variety of specialist advisors, including consultants, doctors, nurses, pharmacists, children and adult safeguarding leads, and experts by experience.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Detailed findings

Is it responsive to people's needs?

Is it well-led?

We initially carried out an unannounced focused inspection of key core services at both King George Hospital and Queens Hospital in September, and then returned in October to review the leadership and governance of the trust.

During this time, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital, including the clinical commissioning groups (CCGs).

We held focus groups with a range of staff in the hospital, including doctors, nurses, midwives, allied health professionals, and non-clinical staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

The adult emergency department (ED) saw 43,329 patients between January and October 2016. The paediatric emergency department was responsible for seeing and treating 15,008 children during the same period. Patients who attended the hospital first saw a doctor or nurse from an independent provider who assessed if they need to attend the ED or if they were suitable to attend the Urgent Care Centre (UCC), which was not provided by the trust.

We visited all the areas within the department, which included: resuscitation (RESUS) for patients with life-threatening conditions (which had two bays for adults and one for children with), major injuries or Majors (a 16-bed area for seriously-ill patients and included one high dependency bed, three single cubicles and 12 double cubicles, one of which could be used as a step-down from resus), minor injuries or Minors (six cubicles and one treatment room), the paediatric area (nine beds) and one observation wards consisting of five beds.

We spoke with 21 patients and relatives and 23 members of staff. We examined 17 sets of medical notes for patients who had been treated in the department.

Summary of findings

We rated this service overall as requires improvement because:

- Lack of resuscitation training was rated as high on the corporate risk register and compliance rates for resuscitation training were low for both doctors and nurses.
- One emergency department matron had in-date advanced paediatric life support training (APLS), but no nurse had in-date APLS training.
- Whilst the trust told us it confirmed all training done by locum staff on their induction checklist, this did not include full compliance with sepsis training as identified within a root cause analysis action plan.
- There was poor recognition of and response to patients with suspected sepsis.
- There were poor levels of hand hygiene compliance.
- The air handling unit in paediatrics and minor injuries had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs.
- There was a 59% vacancy rate amongst medical staff and the lack of senior medical staff was rated as high

Urgent and emergency services

on the corporate risk register. This resulted in a high dependency on the use of locum staff, who whilst fully qualified as doctors may not have worked in an emergency department previously.

- In addition, there was a shortage of paediatric nurses which was also rated as high on the corporate risk register.
- The ED failure to comply with the four hour standard was rated as extreme on the corporate risk register.
- Ambulance turnaround time did not meet the national handover indicator for 64% of the time between June 2015 and May 2016.

However:

- Staff told us that they were encouraged to record incidents and said there was good sharing of learning from incidents through e-mail, meetings and training days.
- Junior doctors felt well supported by senior doctors.
- Walk-in patients were effectively streamed and some were redirected back to their GP.
- Staff were compassionate towards patients and there was a frail and older persons advice and liaison team as well as dementia champion nurses in the ED.
- There was a designated observation ward which was used to assess the community support needs of vulnerable patients before being discharged.
- Patients told us they felt staff informed them of what was going on and staff told us they knew who the departmental leadership team and the executive board were.
- Since the last inspection in May 2015 improvements had been made to the department's clinical governance and risk management processes.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- There were low levels of training in resuscitation for doctors and nurses which was also recorded as high on the latest trust risk register.
- At the time of this inspection, no paediatric nurse had in-date advanced paediatric life support training.
- There were poor levels of hand hygiene compliance.
- There was a lack of evidence that learning and understanding of treating patients with suspected sepsis was embedded.
- Ambulance turnaround time did not meet the national handover indicator for 64% of the time between June 2015 and May 2016.
- The air handling unit in paediatrics and minor injuries had been out of service for at least three weeks prior to this inspection. This meant that fridges in which drugs were stored were unable to remain within safe temperature limits which resulted in medication wastage.
- Patient records were not always kept securely kept. We saw that they were occasionally left on top of record trollies and at other times, record trollies were not securely locked.
- Compliance with safeguarding adults and children training was low for doctors.
- There was a high dependency on locum doctors and lack of senior medical staff was rated as high on the corporate risk register.
- The recent corporate risk register recorded there were too few paediatric nurses and rated it as high. Best practice guidelines state a minimum of one registered children's nurse on each shift, which the trust was meeting, however the trust recognised a need for more nurses to address vacancies.

However:

- Staff told us that they were encouraged to record incidents and there was good sharing of learning from incidents through e-mail, meetings and training days.
- We saw evidence that the duty of candour was followed.
- Medication was appropriately stored, administered and recorded.
- There was a high level of compliance with safeguarding training in both adults and children for nurses and staff had a good understanding of potential safeguarding issues in relation to adults and children.
- The use of agency nursing staff had reduced since the last inspection in March 2015.

Incidents

- The trust reported to the Strategic Executive Information System (STEIS), which records Serious Incidents and Never Events.
- The trust had an incident report writing policy and used an electronic incident reporting system.
- The emergency department [ED] reported 29 incidents to national reporting and learning system (NRLS) between August 2015 and September 2015, 53% of these incidents reported by ED resulted in low harm with the balance rated as no harm. The main categories of incidents reported were moisture lesions.
- There were no Never Events reported within ED between July 2015 and June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Serious incidents (SI) are those that require investigation. The department reported four SIs between August 2015 and April 2016, with none declared between May and September 2016. All four SIs have since been investigated and closed. We saw copies of root cause analysis reports, which included lessons learnt.
- The last CQC inspection in March 2015 highlighted that the department did not routinely assess or learn from incidents which occurred. During this inspection, staff told us this situation had been much improved and lessons learned from incidents were shared across teams. A monthly lessons learned log was completed and shared widely across specialities in a bulletin by the trust board.
- Learning was shared in a variety of ways, including during the morning handover, via personal e-mail and on the intranet. We were shown examples of e-mails sent to staff which outlined incidents and learning from them. We observed a morning handover during which staff were reminded of their responsibilities as a result of a recent incident.
- Staff told us how SIs were also discussed at their 'keep in touch' days which were held four times per year. They said this provided them with valuable information and a chance to consider the learning from them.
- Patient Safety Summit meetings were held every week and attended by multidisciplinary staff from all divisions and co-chaired by the Medical Director and Chief Nurse. The focus of these meetings was to review recent serious incidents or a case study presentation and discuss what could be learnt and shared more widely to prevent a similar incident happening again.
- We saw copies of 12 such meetings and noted that the minutes included the details of SIs and learning from them. For example, where an end of life patient had a DNAR (do not resuscitate order) in place from the community, it was agreed that the palliative care team would work with the ED to establish a tool that could be used as the patient entered the front door.
- In addition to those meetings, there were monthly ED quality and safety (clinical governance) meetings. We saw that minutes from these meetings referred to departmental risks as reflected on the corporate risk register.
- Staff said they were encouraged to report incidents and received direct feedback from their line manager, clinical leads and in teaching sessions. Staff were

aware of the incident reporting procedures and how to raise concerns, junior doctors and nursing staff showed us how to report incidents on an electronic incident reporting system.

- However, agency staff told us they had no computer log-in and were dependent upon an established member of staff to record incidents on their behalf. Any follow-up to that incident came back to the e-mail account of the established member of staff and the agency member of staff did not always get feedback.
- There was a lessons learnt board visible in the department for incident learning. Issues noted included storage of stools, fridge temperatures, pressure ulcer reporting, resus challenges, hoists and oxygen checklists.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We were told by the matron that she was confident staff understood their responsibility in fulfilling their DoC which she felt was embedded in how they worked.
- Staff told us that they had a good understanding of their roles and responsibilities in relation to the DoC. A consultant told us it was of paramount importance that patients and relatives had confidence that the hospital was open and transparent and fulfilled their duty of candour to them.
- We saw from minutes of weekly safety summits that where relevant, a record was made that DoC responsibility had been fulfilled to the patient or their relatives.

Cleanliness, infection control and hygiene

- The trust had up to date policies and procedures for hand hygiene and infection prevention and control.
- There were one case of hospital acquired MRSA and no incidence of C.Diff, or E Coli reported for the ED between November 2015 and August 2016.
- The trust audited hand hygiene compliance in the ED on a weekly basis. Data submitted to CQC for August 2015 to August 2016 showed that results were very poor. For example, compliance varied between a low of 19% in August 2015 to 42% in December 2015. Figures for June, July and August 2016 were 77% 75% and 68% respectively.
- There were dispensers with hand sanitising gel situated around the ED walls including the main waiting area and reception. We saw there were at least three which were empty during the course of our inspection.
- During our inspection, we observed staff did not consistently comply with hand hygiene practice. Not all staff regularly cleaned their hands as they moved around the ED from one area to another, or when leaving or entering the department. This was raised as a consistent issue on most staff meeting minutes we reviewed.
- We saw that vital signs equipment was not always cleaned before being used on another patient.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted that staff generally adhered to the "bare below the elbows" guidance in the clinical areas.
- Most of the equipment we examined such as commodes, vital sign monitors, wheelchairs, toilet rising seats was visibly clean. We saw 'I am clean' labels were in use to indicate when equipment had been cleaned. We also observed staff cleaning beds as soon as they were vacated.
- We observed domestic staff cleaning the department throughout the day and they undertook this in a methodical and unobtrusive way.
- Disposable curtains were used in the cubicles and we found that most were clean and stain free with a clear date of first use indicated on them.

Environment and equipment

- The air handling unit was not working on the day of our inspection which affected paediatrics and minor injuries areas. There were fans strategically placed around the department to mitigate against this. Staff

told us this had been recorded as an incident 3 weeks earlier. However, we were told that it had made working conditions very challenging for staff and uncomfortable for patients as the weather had been very hot during most of the time when the cooling system was out of action. There was a lack of clarity as to when this situation would be addressed.

- We saw this had been added to the corporate risk register on the first of August, with a review date set for October. The risk register referenced the fact that drugs fridges were unable to remain within safe temperature limits which resulted in medication wastage.
- We noted that the drugs room temperature had reached a maximum temperature of 25 degrees. There were fans in situ to control the temperature and we saw an action plan in place should the temperature exceed 25 degrees on seven consecutive days, which included the relocation of perishable drugs.
- There was an over-full sharps bin in the department, which had a used cannula sticking out of the top. The bin was removed immediately when we drew this to the attention of a nurse.
- The paediatric resuscitation trolley was correctly stocked. Regular checks were carried out which included twice daily checks of supplies, a weekly opening of the trolley to check for out of date drugs and weekly testing of equipment. We looked at a record of checks done for the previous six weeks and saw there were no gaps. The nurse in charge told us that staff understood the importance of carrying out these checks and failure to do so could result in disciplinary action.
- There were three resuscitation bays in the adult ED, with one bay dual equipped for paediatric resuscitation. We saw that daily checks were made of resuscitation trollies and equipment, however, these were not always done twice in accordance with the departmental policy. This was recorded in monthly audits.
- We checked three trolleys and mattresses and all were clean. There were no tears in the mattresses and brakes and cot sides were in working order.
- The secure room for mental health patients met the standards set out by the Psychiatric Liaison Accreditation Network. It had two doors which opened outwards and a viewing window. Furniture was secured to the ground and there were no ligature points in the room.
- Data supplied by the trust showed that in almost all cases, equipment in paediatric and adult ED had been serviced within the past 12 months.

Medicines

- Medicines were stored appropriately and controlled drugs were kept in a locked cupboard. We checked the logbook and saw checks were carried out twice daily.
- Fridges were locked to ensure safety and security of medicines. We saw a record which confirmed that staff checked and recorded current fridge temperatures daily.
- The pharmacy reviewed ED drug supply requirements on a daily basis. We saw a member of staff had done a daily stock check and restocked items as needed. ED staff said that each member took responsibility to note low stock and place it on an order list.
- There were pre-filled syringes for emergency medicines (adrenaline, atropine etc.) stored on trolleys, which allowed nurses to access them quickly. These were stored in plastic boxes and on the day of our inspection, we noted that the plastic seal on one box was not correctly attached, which meant that the drugs within could be easily accessed. We drew this to the attention of the matron, who removed it from service immediately.
- Patient records contained appropriate documentation of medicines prescription and administration. We saw that children's weights were recorded in order to ensure the correct dose was administered in relation to their weight.

Records

- Medical and nursing records were kept together in a single set of patient notes, which were kept in a trolley by the nursing stations. However, we saw that they were not always securely kept. On at least three

occasions, we saw that patient records were left out on top of trollies, accessible to members of the public. We also observed that the record trolleys were not locked at all times.

- We reviewed 17 records and saw that allergies were recorded and where appropriate, analgesia and antibiotics were prescribed and administered in a timely manner.
- We saw that national early warning scores were recorded in order to provide early warning of potential clinical deterioration of the adult patient (NEWS) and paediatric early warning scores (PEWS) were recorded on paediatric records.

Safeguarding

- The practice development nurse showed us the current status of nurse training within the department. We saw that there was 100% compliance with safeguarding adults training level 2 and 97% compliance with level 3 safeguarding children.
- Completion of safeguarding training by doctors was significantly lower. Compliance with safeguarding adults level 2 was 73% and safeguarding children level 3 was 60%.
- We saw there were up to date adult and children safeguarding policies available for staff to access on the intranet and staff whom we spoke with could demonstrate where to find them.
- There was evidence that the department had a robust approach to child and adult protection. All children who attended the department were immediately assessed to identify if they were 'at risk'. The paediatric department had access to social workers and a health visitor team who were located within the hospital.
- There was a site based safeguarding adults lead and coordinator, a learning disability lead and a mental health lead.
- The department had a safeguarding screening tool as part of the booking in process. This not only helped to identify if the patient was at risk, but also if anyone related to the patient could be at risk. It would identify, for example, if there were unattended young children at home or, in the case of adults, whether a patient's partner could be at risk from the patient.
- The paediatric unit had effective working relationships with other professionals in the hospital and in the wider community. We looked at four sets of paediatric patient notes and saw that the screening process had been completed. We saw a record on one where contact had been made with a health visitor for clarification purposes.
- A nurse told us how there were regular safeguarding meetings with police, social workers, a drugs and alcohol team and a domestic violence team. They said that these meetings helped to share knowledge and learning about particular trends in the area and also to identify at risk families.
- Staff in the paediatric ED demonstrated a good level of knowledge of child protection issues. They spoke confidently about how they remained vigilant about the possibility of child protection issues whenever a child entered the department and how they would raise an alert.
- Staff we spoke with had a good understanding of safeguarding concerns for adults. They could give examples of ways in which an adult presented as being at risk. They showed us on the patient electronic system how they would raise an alert with the safeguarding team.
- We noted that the following policies were out of date - Infectious diseases expiry date February 2015; Antibiotic collection plan expiry date June 2013; Mass casualties plan expiry date Oct 2013; Winter Resilience plan expiry date Sept 2015.

Mandatory training

- We looked at the departmental nurse training matrix up to the end of October and saw there were high compliance levels with most mandatory training. Moving and handling was 96% information governance was 97% and equality and diversity was 99%. In addition, infection prevention and control was 99%.
- Compliance rates for medical staff with mandatory training were lower in some areas. For example infection prevention and control was 89%, equality and diversity was 87% and information governance was 94%, but moving and handling was 100%.

- However, concerns were expressed by several staff about the poor level of compliance with resuscitation training. Matrons told us there was an expectation that they would deliver resuscitation training which had the potential to have a significant impact on their overall workload. The trust confirmed that at the time of our inspection, there was a reliance on two matrons to deliver resuscitation training.
- We saw that the lack of available resuscitation training at all levels was on the latest corporate risk register and was rated as high risk. The latest review of this risk showed that it was partially assured as there was on-going development of all nurses in resus competency.
- We were told that locum medical and nursing staff were provided via a third party organisation which was responsible for ensuring that all staff had appropriate training, including resuscitation training. The trust wrote that this was confirmed on an induction checklist when the member of staff presented to work. However, it was unable to supply us with data to evidence the fact that they were assured all locum and agency staff had appropriate resuscitation training.
- The trust had a threshold target of 90% for compliance with resuscitation training. Data supplied to CQC demonstrated that compliance rates for nursing staff with level 2 adult basic life support (BLS) was 86% and level 3 adult immediate life support (ILS) 73%. Compliance with Level 2 basic paediatric life support (BPLS) was 87%.
- Compliance rates for medical staff with level 2 adult BLS was 77%. There was no data supplied for compliance with level 3 adult ILS and the trust has not made it clear to CQC whether any medical staff were trained in adult ILS. Compliance with Level 2 paediatric BPLS was 80%.
- Data supplied by the trust showed that nursing staff were 92% compliant in adult basic resuscitation whilst medical staff were 85% compliant with a target of 90%.
- Figures for paediatric basic life support were at 86% for nurses and 80% for doctors, where the target rate was 90% for all.
- Nurses were 73% compliant with intermediate life support and 100% compliant with advanced life support for adults (ALS).
- We were told that FY2 doctors were required to have ALS to work within the trust, and this was checked as part of their induction into the Trust. The trust told us that these doctors did not get signed off for their next year unless they had this level of resus training.
- Doctors were 92% compliant with ALS and 58% advanced paediatric life support (APLS).
- The data submitted confirmed whilst one ED matron had APLS, no nurse in the department had. A paediatric nurse told us that whilst all current paediatric nurses had basic paediatric life support (BPLS) and paediatric life support (PLS), all of their advanced paediatric life support training (APLS) had expired.

Assessing and responding to patient risk

- We were told that patients who arrived by ambulance as a priority ('blue light') were transferred immediately to the resuscitation area. The ambulance service called the hospital in advance for these cases and staff were aware of their arrival so could plan accordingly. There were no priority calls on the day of our inspection to observe this process.
- There was no 'rapid assessment and treatment' in place for other patients who arrived by ambulance. Instead, there was a nurse-led assessment which was carried out by a band 6 nurse. Following this assessment, patients were seen by a doctor in order of priority based on their assessment score and coordinated by the nurse in charge. The matron we spoke with told us this system worked well and had the effect of improving flow. There was no data for us to see how well this worked in relation to the national indicator set by the government of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department.
- Ambulance turnaround time did not meet the national indicator for handover. The indicator for ambulance handover was 15 minutes, however between June 2015 and May 2016 there were 9,806 ambulances with a turnaround of more than 30 minutes at King George

Hospital (64% of all ambulance journeys), with 8% of these delayed over 60 minutes, known as a 'black breach'. There had been no black breaches between June and August 2016.

- Trusts in England have a national indicator for triaging 95% of patients within 15 minutes of their arrival in the ED. This means that they should have an initial assessment with a nurse or doctor. The percentage of patients seen within 15 minutes between August 2015 and August 2016 averaged over 70%.
- We saw a root cause analysis (RCA) report of a serious incident in February 2016 where a patient was discharged home with a working diagnosis of sepsis by the ED Team, which had a very poor patient outcome. The RCA identified, amongst other things that regular 30 minute observations were not carried out by the nurse, in accordance with the sepsis care pathway. Included in the identified recommendations within the action plan was full compliance with sepsis training for doctors and nurses including agency nurses and patients with a diagnosis of sepsis to be referred to specialty and adherence to the sepsis pathway (including 30 minute observations) as high priority.
- Data submitted by the trust demonstrated that there was an 85.5% compliance rate with adult sepsis training and 82.3% compliance for paediatric sepsis amongst doctors. Compliance levels were higher for nurses with 98.3% compliance for adult sepsis and 96.5% for paediatric sepsis.
- The trust told us that locum medical and nursing staff were provided via a third party organisation that was responsible for ensuring that they had sepsis training. The Trust said it took responsibility via their local induction checklist to check that this was the case when the member of staff presented to work.
- Data submitted evidenced that just 38.6% of patients received antibiotics within the first hour of arrival to ED in Q4 2015/16 and 46% in Q1 2016/17.
- The matron we spoke with recognised that the response to patients with a suspected sepsis was an area of weakness within ED. They said this was a continuous priority and acknowledged that figures for sepsis response rates were poor.
- One of the ways in which attempts were made to improve this was by the recent introduction of a weekly sepsis huddle during which it was highlighted to staff the importance of recognising and treating a patient who presented with symptoms of sepsis at every opportunity.
- Staff told us that there was a greater emphasis recently placed on sepsis and they had received training on identifying and treating sepsis. Those whom we spoke with displayed a good level of knowledge about treatment options.We saw the 'sepsis six protocol' was used by clinicians in patient's notes.
- Walk-in patients were seen by a streaming doctor or nurse, who decided if they were suitable for the Urgent Care Centre (UCC) or if they needed to go to the main emergency department. If the doctor or nurse decided they were suitable for the UCC, a receptionist then entered their personal details onto the computer with brief details of the patient's condition. If it was not appropriate for the patient to be seen in the UCC, they were seen by the triage nurse from the A&E department instead, who assessed their condition.
- We saw that patients in four cubicles could not access their call bells, which were still attached to the wall.
- The department used a recognised National Early Warning Score (NEWS) to assess patients and identify if their condition was deteriorating. We found that there were appropriately completed NEWS monitoring forms on those records we viewed. Staff we spoke with were aware of the process and made frequent records of patients' vital signs.
- However, data supplied by the trust showed that there was inconsistent quality in recording of vital signs with overall scores varying from 92% in May to 53% in July and 80% in September.
- This data indicated that 100% of NEWS were calculated correctly for May and June whilst in July only 80% were correct, August 90% and September 90%.
- Staff in the paediatric ED used a paediatric early warning score (PEWS) to identify the deteriorating

child. There were four different PEWS records used, dependent upon the age range of the child. We saw there were age appropriate PEWS on each of the paediatric records we looked at.

- There was a paediatric sepsis trolley and a nurse showed us the paediatric sepsis pathway which clearly outlined the protocol to follow in the event of a child having suspected sepsis.

Nursing staffing

- Data supplied by the trust showed that there was a 12% nursing vacancy rate in ED, with band 5 nurses having the most vacancies.
- Most staff we spoke with told us how staffing had improved since the previous CQC inspection in March 2015. They said that whilst the ED was busy, this was due to an increase in patient volume rather than low numbers of staff.
- Nursing staff new to the department told us they had experienced a robust initial induction. We subsequently saw a copy of the 'ED nurse orientation pack'. This was a comprehensive information pack which aimed to introduce the nurse to the department and to assist with the development of knowledge and skills. The orientation pack included information on the safe handling of medicines and the sepsis pathway for both adults and children.
- The matron told us that a recent merger of rotas with Queens's hospital made it easier to have the correct skill mix in the department. If there was a shortage of a particular band of nurse, then the merged rota made it possible to assign the shift to a nurse from Queen's.
- We saw the nursing e-roster and noted that there was a reduction in the use of agency and bank staff in the two weeks prior to our inspection as staff recruitment increased.
- We looked at nursing rotas for the previous 12 weeks and saw there was a good skill mix. We noted that most vacancies were filled with bank staff and it was evident from the rota that staff on training were not included as part of the rota on that day.
- We saw evidence of forward planning to create a skill mix of nurses. There were opportunities for staff to work extra shifts which were evenly distributed amongst the staff team.
- The matron told us the preference was to have two paediatric nurses on duty in the paediatric ED at all times. However, there had been challenges to ensuring this, although the merging of the nursing rota with Queen's hospital had eased the problem.
- Where there was only one paediatric nurse on duty, the mitigation was to rota a 'paediatric competent' band 6 adult ED nurse. We spoke with a band 7 nurse whose responsibility it was to assess paediatric nursing competencies. They told us these assessments had fallen behind schedule as a result of additional administration tasks they had to perform. However, these additional tasks were recently removed from their workload and they expected to increase the numbers of paediatric competent nurses in the department over the coming months.
- We saw the lack of adequate paediatric nursing capacity was rated as high on the recent corporate risk register.

Medical staffing

- Data supplied by the trust for September showed that there was a 59% vacancy rate amongst ED medical staff, with the largest vacancy rate for consultants (54%), specialty doctors (90%) and specialty registrars (32%) for ED.
- We saw that during the period September 2015 to 2016, the average shift fill rate by permanent staff for middle grade doctors varied between 33% and 55%, for junior doctors it was between 50% and 76% and for consultants it varied between 22% and 67%.
- We saw that the most recent corporate risk register included inadequate senior medical support as a high risk which was placed on the register in June 2016. Reasons cited were the lack of senior support to resus and delayed decision making. This meant that the department was reliant on locums, some of whom lacked the confidence to make decisions about patient care.

- We saw that the most recent assessment of this risk was that it was partially assured by the deployment of staff across both King George and Queen's site.
- The cohort of consultants worked across both King George and Queen's hospital sites. Data submitted to CQC confirmed that the establishment figure for consultants was 18, whereas there were just 9.8 in post at the time of our inspection with the balance made up of locum consultants.
- There was 24 hour on-site consultant cover in the ED on Tuesday, Wednesday and Thursday. On the remaining days, cover was between 08:00am and 10:00pm, after which, the on-call consultant was based at Queen's hospital, contactable by telephone, with registrar cover on-site at King's hospital. The consultant we spoke with told us this was proportionate to the differing demands of both hospitals.
- There was a paediatric consultant based in the paediatric ED from 9am to 10pm Monday to Friday, with a paediatric on-call consultant between 10pm and 9am. At weekends, on-site cover was between 09:00am and 10:00pm, with support from the adult ED consultant outside these times.
- Rotas we looked at for the previous 8 weeks confirmed that the staffing levels reflected the information we were given during our inspection.

Major incident awareness and training

- There was a head of emergency planning who worked across both King's hospital and Queen's hospital site. They told us they had developed a major incident training programme, which was a rolling programme designed to reach as many staff as possible. Staff had to attend one and a half days training in order to complete the course. The head of emergency planning was in the process of getting the training course accredited for continuous professional development purposes.
- We were told that there was an annual chemical, biological, radiological and nuclear emergency (CBRNE) training day, when staff practised to get into full CBRN suits.
- We inspected the major incident room. We saw 'injury specific' packs (eg: gunshot, toxic substances and burns) and noted that all contents were in date and equipment had been recently audited. There was portable blood pressure monitoring screens in stock as well as a decontamination tent. CBRNE suits had been recently audited and inflated as evidenced by audit date stickers. There were separate service outlets (water, electricity) outside the equipment room beside the decontamination area.
- Staff whom we spoke with told us of a recent table top exercise held in conjunction with the London Fire Brigade. Nurses could demonstrate how to access the major incident plan on the intranet.
- However, we noted that the major incident plan was last updated in Aug 2013 and the CBRN policy was overdue a review since February 2015.
- We were told that updated policies were in the process of being developed, to include the new training programme and more recent guidance on how to respond to a CBRN emergency.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- We found a number of clinical guidelines on the trust intranet were out of date.
- There was issues with access to trust policies and guidelines for agency staff who had no computer access.
- The department performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock, asthma in children, and paracetamol overdose.
- There was little evidence of consent recorded on patient's notes.
- The ED should be able to demonstrate that they record patient's skin integrity and fluid intake.
- Nursing and medical staff appraisal rates were below the trust target.

However:

- There was a pathway identified for point of care ultrasound in ED.
- The department carried out a number of local audits including a monthly pharmacy audit on safe and secure management of medication.
- There was good pain relief support for adult and paediatric patients.
- The department ran multidisciplinary keeping in touch (KIT) days in order to provide staff with training for their development.
- There was protected time allocated for teaching for doctors and nurses and junior doctors told us they had good support from senior doctors.
- There was good multi-disciplinary team work within the hospital and with external agencies.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and local policies were written in line with these.
- Staff showed us how they would access the local guidelines on the trust intranet. They said they could access these easily and frequently referred to them to ensure they were working according to those guidelines.
- However, agency staff did not have computer access and relied on permanent staff to enter information on their behalf.
- There were specific treatment pathways for certain conditions. For example; sepsis, fractured neck of femur, acute cardiac syndrome, renal colic and head injury. We found evidence in patients' notes that the fractured neck of femur had been correctly followed. We also saw there was a pathway identified for point of care ultrasound in ED.
- However, it was apparent that the sepsis pathway was not always appropriately followed as evidenced in what has been previously written under the 'safe' section of this report. This was acknowledged by a matron who told us that the response to patients with a suspected sepsis was an area of weakness within ED.
- Local audits included the recognition and management of sepsis in the paediatric ED, documentation in the ED and managing safeguarding concerns in the ED.
- Consultants told us they had a commitment to ensuring that junior doctors were involved in local audits to aid their learning.

Pain relief

- The trust scored similar to other trusts in the A&E survey 2014 related to pain relief being offered to patients.
- Staff we spoke with were aware of the appropriate guidance on providing pain relief to patients. We saw patients being offered pain relief throughout our inspection.
- Patent records we looked at contained completed pain charts and patients we spoke with told us they were offered pain relief soon after they came into the department.
- We saw leaflets in the children's ED to describe levels of pain, which were in child friendly design. This included a series of facial expressions, scored from one to ten, depending on the severity of pain. We saw a nurse asking a child to point to the face that best described how they felt.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of being under nourished.
- However, audits submitted by the trust for February to August 2016 demonstrated that there were poor results for the recording of skin care and fluid intake. For example, the skin care audit did not record any scores for February May and June. The compliance rate for March was 90%, April 100% and August 56%
- Fluid chart audits for the same period looked at accurate recordings of fluid intake and output. There were no results recorded for six of these months, April was the only month recorded and showed 100% compliance.

Patient outcomes

- There was trust wide participation in the RCEM audit report 2013/14 for Severe Sepsis & Septic Shock, Asthma in children and Paracetamol overdose.
- It performed poorly in the severe sepsis and septic shock audit for oxygen administration, documentation of lactate levels blood culture levels and urinary output in the emergency department.
- In the paracetamol overdose audit 2013/14, the department performed lower than the England average in three of the four indicators, including patients receiving the recommended treatment in line with MHRA guidelines (42%) and the proportion of cases that received N-acetylcysteine (a medication used to treat paracetamol overdose) within 8 hours of ingestion. The department was expected to meet this standard in 100% of cases.
- Recommended areas for improvement included ED clinicians to carry out a plasma test if unable to ascertain overdose size, and better documentation of capacity to consent in patients who declined treatment.
- The asthma in children audit 2013/14 showed that the trust performed well with timely recording of respiratory rate, oxygen saturations, pulse and temperature and also the administration of oral or intravenous steroids in the ED. It did less well with the re-evaluation of vital signs post bronchodilator administration.
- The department carried out a number of local audits including a monthly pharmacy audit on safe and secure management of medication, the results of the three audits we saw were positive, with no issues noted. Other audits included a weekly check of medical charts to ensure they were signed and dated and whether any critical drugs were omitted. There were no problems identified with these audits.
- A trust wide audit of falls in ED in September 2016 showed there was poor compliance with the falls pathway, where just 40% of patients had their falls pathways completed. 23% of patients had their lying/sitting blood pressure recorded and 20% had a completed care plan.
- The department scored well in the September 2016 trust wide skin risk assessment audit for body mapping and scoring and reporting any initial pressure sore or skin break on arrival. However, the audit found that there was no skin inspection documented at care rounds.
- Data submitted to us following our inspection recorded no incidence of falls or acquired pressure ulcers between April and July 2016. The data recorded that there were no patients with a decision to admit required for audit during August and September.
- There was a peer review system where matrons from other parts of the hospital audited patient notes for compliance and legibility. The ED matron told us their department performed well in these audits. We subsequently saw a record of these audits for June July and August which showed compliance rates of 84% 76% and 87% respectively.
- Consultants told us they had a commitment to ensuring that junior doctors were involved in local audits to aid their learning.

Competent staff

- We observed clinical practice by both doctors and nurses was within published guidelines. Staff were competent and demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and RCEM guidelines.
- Junior doctors told us they felt well-supported and had access to training. There was protected time allocated for teaching. They said they were given learning assignments and attended four hour teaching sessions twice a month.
- We were told that trust medical training options were available to locum medical staff. However, the trust was unable to provided CQC with a record of training completed by locums and it was not clear to CQC how the trust had an oversight on locum training.
- We spoke with a consultant responsible for junior doctor training. We were told that each junior doctor is assigned to a senior doctor for additional support. They are required to meet face to face every three months. All the junior doctors we spoke with confirmed this and said they had open access to senior doctors as required.

- A new electronic staff training system was launched in January 2016. Staff told us this was a very easy way for them to ensure all their training was up to date, as it recorded all training they had done and all that they were due to do.
- Medical staff told us there was good support when they needed to attend external courses as part of their skill development. However, some nurses told us it had become more difficult to get funding for external courses.
- A health care assistant told us they had been trained to apply basic plaster casts to patients.
- One nurse told us that cannulation and plastering was not included on the paediatric nursing course. They said this meant that they had to call for assistance whenever these procedures were required, thus delaying treatment for the patient. However, they had addressed this with the practice development nurse and expected to have the appropriate training in the near future.
- Nursing staff spoke highly of 'keep in touch' days, which they attended in their individual teams three times per year. These days were planned and included specific training, such as sepsis, resuscitation and dementia awareness, as well as review of serious incidents and learning from them. A member of the psychiatric liaison team told us they frequently ran sessions for staff about managing patients who presented with mental health issues at these 'keep in touch' days.
- Staff told us that following challenging incidents in the department such as a failed resuscitation, short debriefing sessions were organised to discuss learning and the impact on individual members of staff.
- Data submitted by the trust evidenced that appraisal rates for both nursing and medical staff were low with compliance for nurses at 74% and for doctors 60% where the trust target was 85%.

Multidisciplinary working

- We observed good multi-disciplinary team working and positive interactions across all staff levels within the department. Staff we spoke with told us there was a good working relationship between all levels of staff.
- A consultant we spoke with told us the emergency department had a good working relationship with other hospital departments and noted that staff across the hospital acknowledged that the ED was a collective responsibility. They said that this facilitated better patient experiences as it enabled more rapid admission to other departments.
- Staff in the paediatric department described the positive working relationship they had with local child support services. They told us how they engaged with the child and family consultation service for children who were under eleven years old, and with the child and adolescent mental health services for those children aged between eleven and eighteen.
- We observed a handover from the ambulance service to the ED staff. These were well structured and ensured that all the relevant clinical information about the patient was conveyed appropriately. We spoke with a member of the ambulance service who told us that whilst there were occasions when there were delays in handing patients over, there was always good support from the ED staff.
- We spoke with a nurse from the frail and older person's advice and liaison service (FOPAL). This was an admission avoidance team. They told us that staff in the ED alerted them to all patients aged 75 and above in the department. This enabled the FOPAL team to assess for vulnerabilities and share concerns and information with local social and community services. We were told that there was a high level of support from ED staff which enabled patients to be discharged in a planned and effective way.
- The trust hosted a 24/7 psychiatric liaison service (PLS) for a mental health trust. We spoke with members of this team who told us they had a very good working relationship with nursing and medical staff, where each appreciated the other's skills.
- PLS staff told us they had good access to the hospital computer system. They spoke about doing joint assessments with staff and supporting ED staff by providing mental health awareness training on their 'keep in touch' days.

Seven-day services

Urgent and emergency services

- ED services for adults and children and the UCC were open 24 hours a day, seven days a week.
- There was 24 hour on-site consultant cover in the ED on Tuesday, Wednesday and Thursday. On the remaining days, cover was between 08:00am and 10:00pm, after which, the on-call consultant was based at Queen's hospital, contactable by telephone, with registrar cover on-site at King's hospital. The consultant we spoke with told us this was proportionate to the differing demands of both hospitals.
- We were told there was a paediatric consultant based in the paediatric ED from 9am to 10pm Monday to Friday, with a paediatric on-call consultant between 10pm and 9am. At weekends, on-site cover was between 9am and 10pm, with support from the adult ED consultant outside these times.
- There was on-call radiology support available 24/7 for trauma patients. For other patients, staff told us reporting on CT scans and x-rays was often slow and was available only up to 11pm.
- The pharmacy was open Monday to Friday from 8.30am to 5pm and on Saturdays from 8.30am to 12.30pm. It provided a 24/7 on-call service outside these hours.

Access to information

- The department IT clinical management system allowed staff to have access to detailed and timely information to enable them to care and treat patients in a safe and effective manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Data submitted by the trust showed that there was 95% compliance with Mental Capacity Act training.
- We were told that training in relation to the Mental Capacity Act 2005 was incorporated into safeguarding training. Whilst most staff we spoke with were not familiar with the term 'mental capacity', they understood what it meant once it was explained to them.
- Staff told us consent was mainly obtained verbally for procedures such as receiving medicines and minor procedures.
- We found little evidence of consent recorded on patient's notes. Staff told us they obtained verbal consent before engaging in any procedure with the patient.
- Patients we spoke with told us how staff asked their consent before carrying out any procedures. We heard staff asking patients their consent and this was done in an appropriate manner.

Are urgent and emergency services caring?

Good

We rated this service as good for caring because:

- The ED provided compassionate care and staff ensured patients were treated with dignity and respect most of the time.
- We observed that staff interacted with adults and children in a courteous compassionate and appropriate way.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and had been given clear information about their treatment.
- Staff provided emotional support to patients and relatives and could signpost them to other support services if required.

However:

- Patient feedback response rates were low.

Compassionate care

- We observed compassionate care delivered by nurses and doctors, particularly to children. We observed a nurse taking blood from a young child, and they offered reassurances throughout the procedure.
- Staff engaged in an open and positive way with patients and their relatives. We saw how they took time to answer questions raised and were honest

about whether they knew the answer or not. At one point, we saw a nurse ask a doctor to explain to a patient about certain aspects of their care in order to provide reassurance to the patient and their relative.

- Patient feedback was collected through the NHS Friends and Family Test. The trust recognised that patient response rates were significantly lower than the target of 20%. For example, response rates for April, May, July and August 2016 were 3%, 17%, 16% and 13% respectively. The response rate for June was 24%. Of these, positive responses varied between 79% and 90%.
- General observations confirmed staff respected the privacy and dignity of patients.

Understanding and involvement of patients and those close to them

- Most patients told us they felt informed about the processes in ED. They said that once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- Parents accompanying their children in the children's ED were positive about the treatment their children received. They said the nurses and doctors understood them and were supportive.
- Most patients and relatives commented positively on the knowledge and professionalism of the staff who treated them. We were told “the nurse was very gentle when she removed my drip”.
- Most patients we spoke with were positive about their interactions with all staff in the department.
- There were mixed views expressed about reception staff. Whilst some patients told us, “the reception staff were polite and friendly, others said “some of the reception staff lacked compassion and seemed more keen to speak to their colleagues rather than book me in.”

Emotional support

- The ED staff had a protocol on how to support relatives who experienced bereavement. We witnessed how staff dealt with recently bereaved relatives in a most caring and compassionate way.

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

Good

We rated responsive as good because:

- Walk-in patients were streamed effectively, including back to their own GP.
- The environment of children’s ED was child friendly and well laid out.
- There was a frail and older persons advice and liaison team which worked closely with the ED department.
- There were dementia champion nurses in the ED.
- The trust hosted a 24/7 psychiatric liaison service.
- The observation ward was used to assess the community support needs of vulnerable patients before being discharged.
- Where possible, complaints were dealt with swiftly in order to prevent escalation.

However:

- The ED failed to meet the four hour national standard for treating or admitting patients. There was a steady drop in the average four hour attainment performance between October 2015 and March 2016, though this had steadily improved since April.
- Patients were not offered drinks on a regular basis.
- There was no viewing room where people could see their deceased relatives.
- It was unclear how complaints and the learning from them was communicated to staff.

Service planning and delivery to meet the needs of local people

- Certain categories of patients were not taken to the department. These included children, certain cardiac patients, stroke and gynaecology patients. Instead, they were taken directly to the other hospital in the trust, Queen’s hospital, which had a wider range of specialisms.

- We were told that ambulances knew which patients to take directly to Queen's. In the event of a walk-in patient requiring support from a particular specialism which was unavailable at KGH, then they would be stabilised as required and transferred out to Queen's hospital with all relevant information about their condition relayed to awaiting staff.
- Walk-in patients to the department were initially screened by either a nurse or doctor from Partnership East London cooperative, which was hosted by BHRUT. We spoke with a nurse from this service who told us the screening helped to direct patients to the most appropriate area. This could be to see a GP in the urgent care centre, admission to the main ED or to be redirected to their own GP or local community service.

Meeting people's individual needs

- There was no provision to treat ophthalmological or gynaecological emergencies at King's hospital. We were told that walk-in patients presenting with these conditions would have an initial assessment and then be transferred to Queen's hospital whilst ambulances dealing with patients who presented with those symptoms took them straight to Queen's hospital.
- The adult ED had a screen which displayed waiting times and was updated every two hours.
- The layout of the reception area challenged dignity and privacy. There was no 'wait behind' line and there were four windows side by side where patients presented, which made it possible to hear other patient's problems.
- The reception desk was high which made it difficult to see and communicate with a person in a wheelchair. We spoke with a receptionist about this and were told that when it was noticed there was a person in a wheelchair, they would come out to speak with them.
- The relative's room had been refurnished since the last CQC inspection and appeared clean, with adequate seating. There was no separate viewing room where people could see their deceased relative within the ED.
- The environment of children's ED was child friendly, with toys, books and a television. The reception area was well laid out and based around the nurse's station. Children there could be observed by staff at all times. There were dedicated nursery nurses in the paediatric ED who were well integrated into the team.
- The paediatric ED did not have a dedicated play specialist. The nurse we spoke with told us they could access a play specialist from a ward, but this was done infrequently and there was not always one available at the time. They told us that whilst they did not think the lack of play specialist affected their provision of care, they said it would be helpful.
- Adults with learning difficulties who attended the ED had a hospital passport which assisted them to provide hospital staff with important information about them and their health when they were admitted to hospital.
- There was a frail and older persons advice and liaison team (FOPAL) which worked closely with the ED department. Their role was to assess patients over 75 who were of concern and assist with admission avoidance. They linked with community services, including social workers and allied health professionals.They also offered general support and guidance to staff about frail elderly patients.
- In addition, there were dementia champion nurses in the ED. Staff we spoke with demonstrated good knowledge about how to support people living with dementia.
- The trust hosted a 24/7 psychiatric liaison service (PLS) for North East London NHS Foundation Trust. This team worked closely with ED staff to improve the quality of care experienced by those patients who presented to the department and had an associated mental health illness.
- Data collected of nutrition and hydration over a 10 day period in October 2016 evidenced that there was good nutrition and hydration offered to patients between 8am and 3pm. However, it deteriorated later into the evening with no record of patients being offered nutrition or hydration after 9.30pm.
- We were told that a hostess offered food to patients three times per day. In addition to this, there were two

hourly comfort rounds, where patients were offered drinks from a trolley, which was then recorded on patient notes. We saw recorded evidence where drinks were offered and accepted.

- However, we did not see evidence of this two hourly round occurring on a regular basis. Some patients we spoke with told us they had not been offered any drinks, despite being in the department for over two hours, whilst others said they had been offered a drink as soon as they arrived.
- We were told that a housekeeper had recently been appointed, and once they were in post, the view was that the provision of food and drink to patients would be better regulated.
- There was a 24/7 chaplaincy service available. There were chaplains representative of several major religions including Church of England, Baptist, Roman Catholic, Islam, Judaism, and Sikhism. The hospital provided an on-site multi-faith room.
- Translation services were provided by Language Line – usually by telephone but sometimes on a face-to-face basis.

Access and flow

- Trusts in England were given a national indicator by the government of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The trust's performance with regards to waiting times was inconsistent and the national indicator was very rarely met. The indicator had been met by the department on just one occasion between August 2015 and August 2016.
- There was a steady drop in the average four hour attainment performance between October 2015 and March 2016, with percentages decreasing month on month from 90% in October to 76% in March 2016.This percentage improved in April 2016 to 80% and 81% in May.
- However, the trust performed better than the England average of 82% in attaining the four hour standard in June July and August 2016 where data showed performance at 90% 87% and 93% respectively. Staff we spoke with attributed this to better bed availability throughout the hospital, where the emphasis was placed on earlier discharges occurring more frequently.
- We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed decision making impacted on patient care.
- The percentage of patients who left without being seen was higher than the England average of 2.7% in all months between January 2016 and August 2016, with an average of 5.5% over these months.
- Patients who arrived by ambulance, other than those who needed to go immediately to resuscitation area, were seen by a rapid assessment and treatment band 6 nurse. They listed patients to be seen by a doctor in order of priority. This process ensured that patients received an early diagnosis by a clinician and increased the probability of a positive outcome.
- Patients who walked into the department were seen by a doctor or nurse at the front counter. They were then either streamed to the A&E department, or, if less serious, the UCC, which was open 24 hours a day, seven days a week and run by a separate provider.
- We saw the departmental escalation plan (full capacity protocol) which was issued in July 2016. This set out clear pathways and processes to be followed when there was a failure to deliver patient flow through the department as usual.
- The protocol gave guidelines on when it should be activated. For example, when more than 30% of patients waiting for admission waited over two hours for a bed, when the volume of patients arriving per hour exceeded capacity (30 per hour). This was then escalated to the declaring of an internal incident.
- Staff we spoke with were aware of this protocol and told us it gave them reassurance to know it would be initiated when required.

- Nurses in the paediatric ED told us they kept a supply of simple antibiotics, inhalers, eye drops and inhalers in stock. This enabled patients to be discharged quicker with these drugs, rather than having to collect from the pharmacy.
- There was an observation ward which had three beds which were not mixed sex beds. Beds were not for the use of ward patients and there was one nurse assigned to monitor the patients at all times. Use of this ward helped to free up cubicles in the ED.
- The matron told us this ward was used for patients transferred from ED who were ready for discharge, but needed further assessment of their support needs in the community before going home. For example, where a patient was deemed to be vulnerable, a member of the FOPL team would be requested to make an assessment of need prior to discharge. It was also used on occasions when a potentially vulnerable patient was ready for discharge during the night but they could not go home at that time as they would require a support package of care.
- The observation ward was not used for those patients living with mental ill-health. We were told that this was in the interest of safety for the all patients and staff.

Learning from complaints and concerns

- The department had a system in place for identifying, receiving, handling and responding to complaints and comments made by patients and those acting on their behalf.
- Patient information on how to make a complaint or raise a concern with PALS was available on the trust website. Publicity about complaints, in the form of leaflets and posters, was visible in the department and most patients told us they would raise any concerns directly with a nurse.
- ED received 18 complaints between February and September 2016. The three most common causes for complaint were patient unhappy with treatment, delays and attitude of staff.
- We were told that complaints were initially dealt with by the matron. They said they tried to deal with any complaints directly with the complainant as soon as they arose.
- However, it was unclear how complaints were communicated to staff as those whom we spoke with were not able to tell us of any recent complaints or what learning if any was implemented because of a complaint.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Levels of resuscitation for all staff were low, and had been noted on the corporate risk register over a period of time.
- There was no staff grade paediatric nurses trained in advanced paediatric life support at the time of our inspection.
- Whilst the trust told us it confirmed all training done by locum staff on their induction checklist, this did not include full compliance with sepsis training as identified within a root cause analysis action plan.
- There was no divisional nurse lead at the time of our inspection as this post was out for recruitment.
- Many staff with whom we spoke were unclear about the future direction of the emergency department and the impact this had on their job security.

However,

- The departmental understanding of risks and issues generally corresponded with those described by the majority of staff. There was a greater emphasis placed on risk management and better oversight of the risk register since the last CQC inspection in March 2015.
- Staff knew and put into practice the service's values and they knew and had contact with managers at all levels, including the most senior. Staff were able to tell us what the department governance arrangements were.
- Staff knew who the departmental leadership team was and also told us interacting with staff and patients.
- We were told that executive board frequently visited the department and local leadership was very visible

and supportive. The matron and lead nurse held morning briefings to update staff on issues and incidents which may have arisen the previous day and the director of nursing did walkabouts at varying times in order to give as many staff as possible the opportunity to speak with her.

Leadership of service:

- Leadership and management of the department was shared between the two clinical leads and the matrons. These clinical leads shared their time between KGH and Queen's, whilst the matrons were site specific. The senior leaders, clinical director, clinical leads and matrons were all visible within the department.
- There was no divisional nurse lead at the time of our inspection as this post was out for recruitment.
- The recently created role of ED lead nurse was shared across the trust, with the person in post dividing their time between both hospitals.
- Staff told us they knew who the leadership team was and also said that the executive board was visible. This was reinforced by the fact that the board spent one day on site each week and were frequently seen around the various hospital departments interacting with staff and patients.
- The director of nursing met with matrons each week, as well as doing walkabouts at different times in order to give as many staff as possible the opportunity to speak with her.

Vision and strategy for this service

- Staff knew that the corporate ethos was to take PRIDE (Passion, Responsibility, Innovation, Drive and Empowerment – the trust vision) in patient care. Those whom we spoke with told us it was a simple but powerful message and one which they tried to fulfil in the course of their working day.
- Staff told us they had heard about changes to the ED over a number of years and many of those whom we spoke with were unclear about the future of the department.
- A senior clinician told us there were plans which would affect the way in which the emergency departments of both King George and Queen's hospital were run in the future, this had only recently been disseminated to senior staff and there was an expectation that they in turn would share this within their teams.
- However, it was acknowledged that communication with staff could have been more forthcoming in order to allay their fears about their future.

Governance, risk management and quality measurement

- We looked at the most recent corporate risk register and noted there were seven risks recorded, including failure to achieve the four hour standard, with a risk rating of extreme severity. Lack of adequate paediatric nursing capacity was rated as high as was inadequate levels of senior medical support.
- Other risks included inability to provide responsive care to patients in Resus, due to the lack of availability of medical and nursing resource and lack of available resuscitation training at all levels both of which were rated high.
- From our discussions with staff, it was clear that these risks were ones which they were aware of and had concerns about, in particular the lack of paediatric nursing capacity and lack of available resuscitation training.
- There were monthly ED quality and safety (clinical governance) meetings. We saw that minutes from these meetings referred to departmental risks as reflected on the corporate risk register.
- The mortality committee met each month and minutes of two recent meetings sent to CQC showed that ED was represented in one of these meetings. The minutes from May 2016 reflected a wide range of discussions, including a summary of the hospital-level mortality indicator. It was noted that the figure for the 12 month period to January 2016 was 98.9, a decrease from the previous 12 months (100.3) and which was below the UK average.
- Most staff were able to tell us what the department governance arrangements were and told us which individuals had key lead roles and responsibilities within ED.

- There was a short team briefing meeting every morning at 7.30am, chaired by the matron and lead nurse to update staff on issues which may have arisen overnight and deal with any operational concerns. We saw a sample of 8 sets of minutes of meetings which included an update on all recent incidents and lessons learned from them. We noted that poor hand hygiene was a recurring theme.
- There were three bed meetings per day, during which availability of beds across the hospital was updated in relation to the expected need of patients in ED.
- We were told that the formal monthly meeting of nursing staff had become less frequent due to pressures of work, but the intention was to restart them since there were now more staff in post and pressures were lessening.
- There was a trust wide weekly multidisciplinary governance meeting, the discussion included incidents and serious incidents, complaints and audits. We saw this reflected in minutes subsequently submitted by the trust.

Culture within the service

- Staff described the ED as all one team and a small department run with passion. Morale in the department was described as stable.
- We observed good team working among nurses and medical staff, and senior staff told us they were committed to supporting their staff in giving patients good care.
- Matrons told us they met with ward sisters every three months, which helped to promote openness and good communication within teams. We saw minutes of the previous two meetings and noted that the agenda was wide ranging and relevant to current issues within the department such as concerns about low levels of resuscitation training and storage of drugs. Actions were recorded against these

Public and staff engagement

- Feedback from patients was obtained from the NHS Friends and Family test. Response rates were low, but of those responses gathered over the previous five months, 87% of people surveyed would recommend the emergency department at King George Hospital.
- 2092 staff at Barking, Havering and Redbridge University Hospitals NHS Trust took part in the 2015 National NHS staff survey. This was a response rate of 37% which was below an overall average response rate of 41% for acute trusts in England, but represented an increased response of 4% on the 2014 staff survey.
- We looked at overall trust results of feedback from staff in the 2015 National NHS staff survey which was combined for King George hospital and Queen's hospital. The trust scored better than the national average for staff motivation at work, quality of non-mandatory training, percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months, percentage of staff reporting errors, near misses or incidents witnessed in the last month and effective use of patient feedback.
- However, the trust scored below the national average for percentage of staff believing that the organisation provided equal opportunities for career progression or promotion, percentage of staff satisfied with the opportunities for flexible working patterns, percentage of staff experiencing discrimination at work in last 12 months, percentage of staff suffering work related stress in last 12 months and percentage of staff working extra hours.
- There were information boards around the ED, including one which identified the nursing staff and their grade by the type of uniform they wore. Other information boards included advice on how to give feedback and information on quality of patient care for the previous month.
- The trust issued press releases in April and June 2016 in which it was proposed that there would be changes to emergency and urgent care at King George hospital. This included the overnight closure of the department.
- Prior to any changes being made, there would be a series of reviews carried out by an independent team, including senior doctors.
- Following those reviews, there would be meetings of the trust board and the local clinical commissioning group held in public to reach a final decision to implement the changes.

- We saw a draft copy of the trust board joint communications and engagement strategy plan for the proposed changes. This identified the need for internal staff communications to help staff to understand the timing and purpose of decisions and what it would mean for their work and how they communicated the proposal to patients.
- Some staff told us they did not feel consulted or informed about the proposed changes in the way the ED would function. They knew that there were discussions at certain levels, but this information was slow to be shared. We were subsequently told by a senior member of staff that engagement meetings with all staff were planned for the month following this inspection.

Innovation, improvement and sustainability

- The department had introduced a point of care ultrasound (PoCUS). This enables clinicians to carry out ultrasound as required in the ED. It provides relevant information at the bedside rather than transferring a critically ill patient or risking exposure to radiation.
- The department plans to establish an academic unit in 2017 to aid on-site education and development for clinical and nursing staff.

Medical care (including older people's care)

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

Information about the service

Medical care encompasses a broad range of specialties that use non-surgical interventions to assess, diagnose and treat patients. At King George's hospital, these included wards that specialised in urology, stroke rehabilitation, gastroenterology, care of the elderly, acute medicine, endocrinology, endoscopy, cardiology and general medicine. There was also a medical assessment unit (MAU). During the course of this inspection, we visited seven of the medical wards: Ash ward, Beech ward, Erica ward, Fern ward, Gardenia ward, Gentian ward and the MAU.

Between September 2015 and August 2016, there were 12,141 admissions to the medical service at King George's hospital. Of these admissions, 54.3% were emergency admissions and 45.7% were elective. There were 5,323 day case patients in total in the same period. There were 176 inpatient beds and 36 day case beds within the medical division at the hospital.

We visited King George's hospital as part of our unannounced inspection on 8 September 2016 and again as part of a follow-up unannounced visit on 16 September 2016. We spoke with 32 members of staff including health care assistants, nurses, trainee doctors, consultants, allied health professionals, senior staff, domestic staff and pharmacists. We spoke with nine patients and three relatives. We reviewed 20 care records and 20 prescription charts. We observed staff interactions with patients and those close to them. During and following the inspection we requested a large amount of data in relation to the service, which we reviewed and considered when making our judgements.

Medical care (including older people's care)

Summary of findings

We rated this service overall as requires improvement because:

- Hospital environments were not always ideal. Some wards were reported and observed to have high levels of noise and heat. There was a lack of bedside televisions or radios across the wards. There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services.
- Although we observed good infection control practices on inspection, rates of both MRSA and Clostridium difficile infections were high. Infection prevention and control audits, as well as hand hygiene audit results, showed consistently poor compliance in some wards and departments.
- Although nursing staffing levels had improved since our last inspection in March 2015, some wards still had significant vacancy and turnover rates. On these wards, there was a reliance on bank and agency staff to fill vacant shifts.
- There was a reliance on locum doctors across the service, apart from in cardiology. This affected continuity of patient care, particularly out-of-hours. Medical staff across the service were failing to meet trust targets for completion of mandatory training.
- For non-elective admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine. Patient outcomes in care of the elderly were limited by the lack of consultant geriatricians to lead improvements within the service. Junior doctors in geriatric medicine reported lower overall satisfaction than the national average in the 2015 National Training Survey. There was also poor performance in measures such as availability of clinical supervision out-of-hours and regional teaching. These results showed significant improvement in the 2016 survey, but some issues still remained.
- Medical and nursing staff completion rates in basic life support were below the trust target, due to a lack of external training sessions.
- There was still a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust. The trust performed worse than the previous year in a number of national audits.
- Some principles of good record keeping were not being followed. Fluid charts were not always filled out and medical entries were sometimes illegible and unsigned. On Ash ward, we also found that three sets of notes did not have the date of transfer to the ward recorded. There were issues with two out of seven sets of the Deprivation of Liberty Safeguards (DoLS) documentation that we reviewed whilst on inspection.
- The pathology service was understaffed and unable to provide effective cover out-of-hours at the time of inspection.
- The pathways for patients with cancer were not always clear. There was poor communication with tertiary centres, which caused delays with patients requiring tertiary treatment or diagnosis at other specialist hospitals. The trust performed slightly below the national average in the National Cancer Inpatient survey 2015.
- The trust was not meeting 18-week national indicators for non-urgent referral to treatment (RTT) times.
- Staff across the hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place. Some patients and relatives felt that more could be done to involve them in their care, especially surrounding discharge.
- Patients were not always able to be located on the specialist ward appropriate for their condition, although management of these patients had improved since the previous inspection. The number

of patients moved four or more times per admission had increased. In some wards, such as Ash, Gentian and Gardenia ward, bed moves were consistently occurring out of hours (between 10pm and 6am).

- NHS England suspended endoscopy screening invitations to the trust for eight weeks from July 2016. There was a risk of delayed diagnosis of bowel cancer due to inability to provide a full screening service to the local population.
- Patient information leaflets were not standardly available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner. There were no leaflets detailing how to access PALS and make a formal complaint on Gentian ward at the time of our inspection.
- The NHS staff survey results were variable, with the trust still scoring below the national average in many measures. Some comments we received from staff within the medical department reflected that they were not always happy with the leadership or management of the service.

However:

- There was improvement in both the reporting of incidents and the sharing of lessons learned from these across the hospital. Staff were aware of their responsibilities with regards to duty of candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan. The governance structure had been revised to provide a greater level of accountability and oversight of risk.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. They knew how to escalate concerns and were up-to-date with appropriate levels of training.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Magnetic symbols on patient information boards identified those patients at particularly high risk, of falls or pressure ulcers, for example.
- Medicines management had improved, with new processes in place to ensure the safety of patients. Much work had been done since the previous inspection to ensure that discharges were not delayed due to unavailability of take home medications.
- Nursing and medical staff completed a variety of local audits to monitor compliance and drive quality improvement. Staff told us that these led to meaningful change across the service. Both local and national audits were overseen by a committee. In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate.
- Patients were cared for in a caring and compassionate manner by staff throughout their hospital stay. Most medical wards performed in line with the national average in the NHS Friends and Family Test (FFT). Patients' privacy and dignity was maintained at all times. The hospital facilitated a number of forums and listening events to engage patients in the development of the service.
- The trust performed above the national average in measures relating to training and appraisals in the NHS staff survey 2015. The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals. The trust was supporting nurses with the revalidation process. For all specialties apart from

Medical care (including older people's care)

geriatric medicine, the trust scored above the national average for most measures in relation to first year medical doctors in training (2015 National Training Survey).

- There was evidence of effective multidisciplinary working within wards and across departments. All members of staff felt valued and respected by their colleagues.
- Psychological support for patients was easily accessible and timely. Patients were routinely assessed for anxiety and depression on admission. The chaplaincy team offered comprehensive spiritual support to all patients, regardless of religious affiliation.
- People with complex needs, such as those living with dementia or a learning disability, were well considered and cared for within the hospital. Staff made reasonable adjustments to improve their experience of the service and supported them throughout their inpatient stay. Information and environments had been adapted to make them more suitable for these patients.
- The trust had developed a clinical vision and strategy and communicated this to staff of all levels, enabling them to feel involved in the development of the service. Most nursing and medical staff thought that their line managers and the senior team were supportive and approachable. The chief executive and divisional leads held regular meetings to facilitate staff engagement.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire. Regular drills were held to ensure staff were adequately trained in the event of emergencies.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Infection prevention and control audits, as well as hand hygiene audit results, showed consistently poor compliance in some wards and departments. There had been four cases of MRSA between April and September 2016, against a zero tolerance. In the same period, there had been 18 cases of Clostridium difficile infection.
- There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services.
- There were some issues noted with records, such as some medical entries being illegible and unsigned. On Ash ward, we also found that three sets of notes did not have the date of transfer to the ward recorded.
- Medical staff were failing to meet trust targets for completion of mandatory training, across all topics.
- Staff completion rates in basic life support were below the trust target, due to a lack of external training sessions.
- Although nursing staffing levels had improved since the last inspection in March 2015, some wards still had significant vacancy and turnover rates. On these wards, there was a reliance on bank and agency staff to fill vacant shifts.
- Locum usage for medical staff was generally high across the trust, especially in some specialities. In stroke services, rates of locum usage ranged between 18.4% and 34.5% for the period of March 2016 to August 2016. In the same period, locum usage in care of the elderly services ranged between 15.6% and 24.3%.

However:

- There had been an improvement in the reporting of incidents and the sharing of lessons from these across the hospital.

Medical care (including older people's care)

- All staff were aware of their responsibilities with regards to duty of candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan.
- The dispensing and administration of medication had improved, with prescription charts being used correctly and processes being correctly followed and audited.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. They knew how to escalate concerns and were up-to-date with appropriate levels of training.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Magnetic symbols were used on patient information boards to identify those patients at particularly high risk.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire. Regular drills were held to ensure staff were trained for emergency situations.

Incidents

- Staff across the wards were aware of trust wide systems to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. They were able to give examples of when they had used the system to report appropriate incidents. Feedback and learning points from incidents were shared with staff across the service via email and during handovers, daily safety huddles and team meetings. There were also quality and safety meetings held every two weeks which discussed themes and learning from recent incidents.
- There were no "Never Events" reported within the trust in the 12 months prior to our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between October 2015 and September 2016 the trust reported 550 incidents across specialist medical services, and 243 incidents across the acute medicine division at King George's hospital. Across both divisions, 54 incidents were categorised as a 'near miss', 38 were categorised as 'moderate' harm and the majority (696) were categorised as causing 'low' or 'no' harm. The most common themes of these incidents were pressure ulcers, falls, medication errors or omissions and staff shortages. Staff of all levels confirmed there had been a great improvement in both the reporting and sharing of lessons learned from incidents, with one junior doctor commenting that there had been 'a real culture change' in this respect over the course of the previous year.
- At King George's hospital, there were 17 serious incidents reported across the specialist and acute medicine divisions between October 2015 and September 2016. They all related to pressure ulcers and falls, apart from three cases, which related to infection control, poor management of a deteriorating patient and diagnostic delay. Senior staff that we spoke with were able to describe training they had undertaken in the investigation of serious incidents and gave examples of recent serious incidents that occurred in their clinical area. All serious incidents were subject to a full root cause analysis investigation and action plans were developed where areas for improvement had been identified. We saw detailed examples of these for serious incidents that had occurred recently. A new group, which included divisional nurses, quality and safety advisors and medical leads, had been initiated to provide a peer review of serious incident investigations.
- One ward sister gave an example of an investigation she was involved in in March 2016, which involved a patient fall. As a result, practice on the ward changed and all newly admitted patients were subsequently placed in bays rather than side rooms to enable closer supervision. Nursing staff who had not completed training in falls prevention were booked into future sessions. Patients at high risk of falls were also flagged by placing a sticker on boards by their beds and staff made sure to highlight this risk on handover sheets.
- Mortality and morbidity were considered during the monthly mortality assurance group. This group was introduced in 2015 as part of the 'sign up to safety' initiative, which aimed to improve the monitoring and

identification of mortality outliers to identify potential areas where deaths could be prevented. Patient deaths were adequately reviewed divisionally and discussed in order to identify trends or issues of concern that led to learning and subsequent actions to improve care.

Duty of Candour

- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The key principles of the duty of candour regulations were displayed throughout the wards that we visited. We saw examples of letters of apology to patients and their relatives from senior staff when things had gone wrong. Serious incident reports also showed consideration of duty of candour.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free' care. We saw 'quality of care' boards on each ward that we visited that displayed the data relating to performance in key safety areas such as patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE). These boards indicated how many days had passed since the last incident of each of these types.
- Safety thermometer data for the speciality of medicine returned nil values for the period between June 2015 and June 2016, despite many of the categories measured featuring regularly in incident reports. This was due to the trust reporting the incidents under the speciality of 'mixed care', which appeared to account for the vast majority of wards at the trust. Data requested directly from the trust indicated variable levels of compliance with safety thermometer measures. Some wards, such as Erica and Gentian wards, scored consistently highly, with only one month (January 2016) falling below a score of 90% in the period between January 2016 and June 2016. Beech and Gardenia wards scored over 90% in all months in the same period, with the lowest scores in June 2016 (93.3%) and March 2016 (96%), respectively. Other wards, such as Fern and Ash, scored below 90% in four of these six months, with the lowest scores of 76.7% and 85.7%, respectively, in June 2016.
- Patients were assessed for risk of pressure ulcers, VTE and falls on admission to each ward. An assessment booklet had been designed that incorporated standard assessments for each of these risks on admission. Symbols were placed on the patient information board and by each bed to indicate if the patient was at an elevated risk.
- The percentage of patients assessed for VTE risk within 24 hours of admission varied across each ward but rarely exceeded 90%. In the period between March and August 2016, only Fern and Ash wards achieved 90% compliance in two months out of the six, respectively. Gentian ward scored 100% in April 2016 but for all other months, this fell below 90%, with the lowest percentage of patients recorded being 44.4% in March 2016. Gardenia ward and the medical assessment unit (MAU) did not exceed 87.3% and 86.3%, respectively.
- Staff had good access to tissue viability services, through referral to a specialist team. All nursing staff had recently attended training sessions in tissue viability, due to the risk of pressure ulcer development being added to the corporate risk register in April 2016. Nursing staff were taught how to identify early signs of tissue damage and use the Braden scoring system and body maps to record any changes in patients' skin integrity. There were tissue viability link nurses on the ward who attended additional training and shared this with the wider ward team. On some of the wards we visited, there were clocks by the side of patients' beds to indicate when they next needed to be turned. Pressure ulcer panels were held once a month to discuss any incidents.
- Patients at risk of falling were nursed in beds that were capable of being lowered to prevent them from falling out. Bed rail assessments had been completed to enable these to be used to minimise the risk further. The prevention of falls was highlighted as a priority on many of the ward safety boards and staff were able to

access non-slip slipper socks for patients to promote safe mobilisation. The wards had recently introduced a guide to medicines that contribute to falls that was displayed on the inside of all medication trolleys to act as a prompt to nursing team when issuing medication.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice. There was also a lead IPC nurse for the trust and head of IPC, who staff were aware of and knew how to contact if necessary.
- There were 'cleaning matters' boards on each ward that displayed the work schedule for domestic staff, an explanation of what areas were cleaned daily and encouraged patients to tell staff if something needed to be cleaned. Domestic staff told us there were sufficient supplies of cleaning materials available for their use. They were able to tell us about the national colour-coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection.
- The wards and communal areas we visited were visibly clean and tidy. Personal protective equipment (PPE) was available for staff to use. All wards had antibacterial gel dispensers at the entrances and by patients' bedside areas. Green 'I am clean' stickers were in use throughout the wards to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Infection control audits were completed by the Infection Prevention and Control team (IPCT), with frequency depending on the score the ward had achieved in a baseline audit at the beginning of the year. These looked at areas such as use of PPE, hand hygiene, isolation, environment, decontamination of commodes and safe disposal of waste. Although Fern ward scored 95% in this baseline audit, most medical wards scored between 85%-94%, with Ash ward scoring just 81% and Gentian ward scoring just 82%. All wards with these lower scores were offered extra support from the IPCT and action plans were agreed. Most wards showed an improvement in these scores in the subsequent audits. However, data was not provided for Ash, Gardenia, Fern or the medical assessment unit (MAU).
- Staff responsible for cleaning knew of measures they should take to reduce the risk of healthcare-associated infections. Patients with suspected or confirmed healthcare-associated infection were nursed in side rooms. There was appropriate signage on these doors.
- Staff on the wards we visited wore appropriate PPE such as gloves and aprons and utilised effective hand-washing techniques. Hand hygiene audit results for some medical wards were good in August 2016, with Erica and Fern wards scoring 100%, and Gentian and Beech wards scoring 96%. However, other medical wards performed less well, with Juniper scoring 84% and Ash ward scoring 85%. Hand hygiene results on these two wards had consistently fallen below 90% since March 2016 or not been submitted at all. This was despite assurance from nursing staff that issues from audit results were discussed in daily safety huddles and team meetings.
- The trust reviewed rates of MRSA infection in inpatients and highlighted four cases between April and September 2016, against a zero tolerance. For the same period, 18 cases of Clostridium difficile infection were reported, against a trust target of 30 cases for the year. Both of these issues were added to the risk register and action plans were devised, including the daily follow through of all affected patients and an increased focus on hand hygiene audit completion and compliance. The lack of staff compliance with decolonisation cleaning in regards to MRSA was also highlighted, with the policy being adapted to allow decolonisation on admission. Any learning outcomes from continued monitoring were to be incorporated into the infection prevention and control improvement plan for the following year.

Environment and equipment

- The trust had identified breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services. At the time of inspection,

approximately 70% of repair work had been undertaken but some breaches still existed and were not expected to be repaired fully until summer 2017. This issue had been added to the corporate risk register.

- Equipment used on medical wards was clean and labelled to indicate it was disinfected and ready to use. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Staff reported that it was easy to obtain equipment and that there were no issues when urgent repairs were required. There had been a recent investment in new cardiac monitors on Gardenia ward, although the age of the angiography equipment was listed as an item on the divisional risk register. The cost of replacing this equipment was being investigated as the current servicing agreement only extended to March 2017.
- Disposable equipment was easily available, in date and appropriately stored. The service has recently invested in a computerised supply management system, which monitored supply levels and automatically placed orders when stock was low. The system used PIN and fingered print access to identify which staff used which products. However, this was not yet live across all wards.
- There were safe systems for managing waste and clinical specimens. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use. There was one instance where a sharps bin had been left in the corridor outside a waste disposal cupboard but this was remedied by staff.
- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. Emergency drugs were available and within the use by date. Safety alerts had recently been circulated by the resuscitation team to indicate that emergency drugs should be stored inside the resuscitation trolley, for security purposes. Nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items.

Medicines

- Medicines were managed and stored appropriately on most of the wards. Staff kept medicines and intravenous (IV) fluids in locked cupboards or rooms with restricted access to ensure security. Most medications were found to be in date, but we found one refrigerated medicine that was four months out of date on Ash ward and one IV medication which was five months out of date on Beech ward. These were brought to the attention of nursing staff, who removed the items and alerted pharmacy immediately.
- Nursing staff checked medication fridge temperatures daily and took appropriate actions when these were out of normal range. For example, we saw records to indicate that refrigerated medications on Ash ward were temporarily moved to another ward when the fridge was found to be faulty. Pharmacy technicians had recently trained all nursing staff in the safe use of fridges and appropriate escalation of any issues.
- Temperatures of storage areas and treatment rooms were checked daily. On some of the wards, room temperatures had consistently exceeded recommended levels. Pharmacy staff were aware of this issue and had taken actions to mitigate this. On all wards where temperatures had exceeded the recommended temperature for seven days or more, red dots were placed on affected medications to indicate that their use-by date had decreased by two weeks. Staff were advised to take any actions possible to reduce temperatures, such as closing blinds, opening windows, using fans and switching lights off. The issue was reported to estates and an incident form was completed. A working group made up of the lead nurse, assistant chief pharmacist and senior pharmacists had been set up to address the issue. Pharmacy staff kept an operational spreadsheet for each clinical area that recorded and monitored the fluctuations in temperature, any actions that had been taken to tackle the issue and the total cost of any medicine affected. The group was considering drafting a business case to introduce more effective room temperature controls across the hospital.
- We looked at the prescription and medication records for 20 patients. All charts documented VTE assessments and the allergy status of patients. Appropriate arrangements were in place for recording the administration of medicines. Each chart had

separate sections for different types of medications, including 'critical medications', which indicated to nursing staff which medications they should not be delayed in obtaining. Records were clear and fully completed in most cases. They showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded. In a few instances, nursing staff had not signed to indicate that they had given a medication, but this had been highlighted by pharmacy staff, who checked the records daily. A monthly audit of omitted doses indicated improvement across the trust within the last year, with 6.6% of medication doses being missed in July 2016, compared to 16% in October 2015. Staff were encouraged to discuss omitted doses of medication in their daily safety huddles.

- Incident reports were filled out in cases of medication administration errors, with the key themes being identified as omitted doses and administration errors. A weekly pharmacy development group discussed any medication incidents and relevant audit results, as well as a monthly operational group meeting. A monthly medicines safety report was then sent to the senior team, divisional leads and all pharmacists. This report collated all divisional data and highlighted both good practice and key areas for improvement. One improvement that resulted from this was the development of a 'can't find a medicine' flow chart, which instructed nursing staff what to do when medicines were not available on their ward.
- Pharmacy staff reported that there had been significant changes across the service in the last two years. Staffing levels and support from managers were reported to be much better. There were currently two vacant posts in the service, one band 8a pharmacist post and one part-time band 4 pharmacy technician. Both posts were currently being advertised for recruitment. Staff reported that there were enough staff for the current provision of service but that pharmacists may have to cover more than one ward in the event of sickness.
- Staff told us the pharmacy services were easily available and pharmacists visited the wards daily. Four areas had ward-based pharmacists. Staff in other areas indicated that they were able to contact the pharmacist when required. The pharmacy team aimed to carry out medicine reconciliation within 24 hours of admission across all wards. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up-to-date prescriptions are used. Nursing staff told us that this usually took place on the same day as admission, apart from on weekends, when it took slightly longer. In the period between April and August 2016, between 72% and 77% of patients had a drug history completed with 24 hours of admission.
- Controlled drugs were stored in locked cupboards and appropriate staff held the keys. Staff maintained accurate records of controlled drugs, which were checked twice daily by two registered nurses. Nursing staff were aware of policies on the storage and administration of controlled drugs. A review of medications management in this area had taken place in the last year to ensure safe storage and security had been adopted at ward level. Physical controls such as the use of stamps during routine checks had been adopted. Further actions such as improving the security of release of controlled drugs to patients in care homes had been identified. Plans to review the controlled drug registers and modernise them were also in discussion.
- Medicines were usually available to facilitate timely discharge of patients who were going home. The issue of patients being discharged without take home medications was added to the risk register in February 2015 but much progress had been made to improve the existing process. Ward-based pharmacists now helped to facilitate discharges in areas where they were available. There was also a pharmacy discharge team who worked 11am to 4pm weekdays and could be bleeped to prepare take-home medications. Nursing staff were encouraged to order any medications for anticipated discharges as soon as possible. Some wards had introduced a named nurse responsible for discharge planning to ensure this took place. A hospital-wide audit conducted in August 2016 indicated that 89% of take-home medications were dispensed within two hours (against a target of 90%). The average turnaround time for these medications

was 94 minutes. In the same month, 206 requests for take-home medications came in after 4pm (29% of the total requests), which affected the timeliness of their preparation.

Records

- Information governance training was mandatory for all staff working at the hospital. Completion rates for nursing staff in the acute medicine division stood at 95% and 96% for nursing staff in the specialist medicine division, against a trust target of 95%. However, only 78% of medical staff in acute medicine and 85% of medical staff in specialist medicine had completed this training.
- Hospital staff used paper based patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Nursing records were kept at the bedside in folders, whereas medical records were stored in locked trolleys near the nursing stations. Staff reported that there were no issues with this system as all the main risk assessments and care plans were recorded in the assessment booklets used across the trust.
- We looked at 20 sets of patients' records. Information was concise and clear. Conversations with both the patient and family were well documented and detailed. Most notes were dated, signed and followed the trust's note writing protocol, apart from a few instances where entries by medical staff were not signed and were illegible. On Ash ward, we found that three sets of notes did not have the date of transfer to the ward recorded. This was raised with the ward sister, who told us that she would include this item on the weekly audit programme for the following month to ensure compliance.
- Documentation audits took place across the wards each month to ensure that record keeping standards were maintained. These looked at areas such as whether contact details had been fully completed, assessments had been carried out, care plans had been devised and whether entries were clear and legible. A score of at least 80% compliance across all measures was desirable. In August 2016, Gentian ward scored only 65%. Senior staff told us that this was due to the high number of agency staff used that month due to staff sickness, who were not familiar with the note writing protocol. Nursing staff also told us that doctors did not always affix the stickers of cannula packs into notes as expected, and that these were sometimes discarded as a result. Between June and August 2016, other wards scored consistently above 90%, with only a few low results that showed immediate improvement. For example, Gardenia ward scored only 46% in July 2016, but this had drastically improved the following month, with an overall score of 95%.
- We saw examples of good documentation practices, such as the use of charts to record challenging behaviour displayed by those with communication difficulties (caused by stroke or dementia). These aimed to identify patterns and find the root cause of these behaviours so they could be remedied.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the up-to-date trust safeguarding policy on the intranet. Safeguarding was part of the trust annual mandatory training. In the acute medicine division, 96% of nursing staff had completed safeguarding adults level 2 and safeguarding children level 2 training (against a trust target of 90%). For acute medical staff, these figures were 81% and 77%, respectively, falling short of the trust target. In specialist medicine, 97% of nursing staff had completed safeguarding adults training and 95% had completed safeguarding children level 2 training. Specialist medical staff fell short of the trust target again, with only 81% of doctors completing each training course.
- However, both medical and nursing staff at all levels knew who to contact if they wanted further advice and told us that the safeguarding team supported them when they needed advice or guidance. Posters were displayed across ward areas detailing contact details of the relevant safeguarding leads. Most staff were able to give examples of safeguarding referrals or concerns that they had raised. There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes around this, were shared.

Medical care (including older people's care)

Mandatory training

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Senior nurses of band 6 and above were responsible for ensuring that staff that they supervised were up-to-date with their training. Compliance was now monitored through an online system, which alerted staff and managers when their mandatory training was due to expire. This had improved compliance rates across the service and upcoming training sessions were advertised during team meetings and safety huddles. Some staff commented that some practical sessions became fully booked quickly but that the training department was usually responsive in adding extra sessions to meet demand.
- Mandatory training completion rates for nursing staff in the acute medical division were generally good, on the most part exceeding the trust target of 90%. The exception was basic life support, which only 83% of nursing staff had completed in the last year. Nursing staff in the specialist medicine division had exceeded the trust target of 90% in all mandatory training, including basic life support, which 93% of nurses had completed.
- Training rates for medical staff were not as high across both divisions. In acute medicine, completion rates ranged between 75% (conflict resolution) and 89% (infection prevention and control). In specialist medicine, completion rates stood at between 71% (sustainability and waste management) and 91% (equality, diversity and human rights). Only 80% of acute medical staff and 82% of specialist medical staff had completed basic life support training. The issue of outdated basic life support training for both nursing and medical staff had been recognised by the trust and was due to limited capacity on courses running until October 2016. In order to mitigate this, the trust planned to use qualified trainers employed (in other roles) in the division to run local courses to bring staff up-to-date. Additionally, the overall poor compliance with statutory and mandatory training for doctors had been identified divisionally as an area of improvement, owed partly due to the accessibility of training and not fully functional reporting access. Doctors were being contacted individually by specialist managers to improve their compliance.

Assessing and responding to patient risk

- All patients were assessed on admission using national risk assessment tools in nutrition, falls risks, manual handling needs and skin integrity. Initial assessments were completed within 24 hours of admission, with the aim to identify any factor which the patient may need support with and to identify a baseline condition. We observed that processes were in place to ensure that a consultant reviewed all patients within12 hours of admission, which was in line with agreed national standards.
- Magnetic symbols were used on some wards' patient information boards to identify those patients who were at risk of pressure ulcers, falls, had nutritional or communication needs, or those who were living with dementia. Boards also highlighted when patients had similar names to one another, to avoid mistakes being made in their care or treatment.
- Patients at risk of deterioration were discussed in daily safety huddles or 'board rounds', where members of the multidisciplinary team (MDT) gathered to review individual patient treatment plans and conditions. We also witnessed comprehensive handovers between nursing staff that discussed risks to particular patients and appropriate actions that could be taken to mitigate these.
- Nursing and health care assistant staff monitored all inpatients regularly and used a National Early Warning Score (NEWS) to identify patients who were deteriorating. Nursing staff used a separate chart to record observations and corresponding NEWS. We looked at two cases where a score had indicated a risk of deterioration and saw that this had been appropriately escalated for review by a medic. In cases where the NEWS exceeded four points, staff used the adult sepsis screening tool to determine whether this was an issue. We saw sepsis decision trees and care pathways on each of the wards we visited.
- Nursing staff told us that doctors were responsive to bleep calls when they were concerned a patient was deteriorating. Junior doctors and registrars attended

the wards out-of-hours when this occurred, usually within thirty minutes, depending on urgency. Staff could also access advice from the critical outreach team, who were based at Queen's hospital and worked Monday to Friday, from 8am to 6pm.

Nursing staffing

- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the numbers of staff available that day and whether this met the planned requirement. This was in line with Department of Health guidance. Staffing levels were appropriate for the acuity and dependency of patients. The Trust used the Safer Nursing Care Tool (SNCT) as an indicator for safe staffing levels across relevant ward areas within the Trust.
- Staffing levels had improved since the last inspection but varied across the medical wards, with some areas having more vacancies than others. Senior staff told us that some wards had no problems recruiting staff to vacant posts. For example, Gardenia ward had three vacant nursing posts but these had already been advertised and candidates had been shortlisted. The ward sister had recently put forward a successful business case for an extra healthcare assistant (HCA) to work during the night to improve patient safety. Beech ward had just recruited one new nurse who was due to start work in October and had employed five new starters recently. Gentian ward had two vacant band 5 posts. One post had been filled and the other was out on a rolling advertisement.
- On other wards, recruiting staff into vacant posts was more problematic but there was recognition from senior staff that this was an issue and measures had been taken to improve the situation. A trust recruitment and retention group was established and met monthly to drive action and monitor progress. Fern ward had 11 whole time equivalent (WTE) nurses against an establishment of 19. Nursing staff turnover for care of the elderly trust wide was 26.17% at the time of inspection. Ash ward had filled two vacant band 5 posts with nurses waiting to start and two further band 5 nurses on long-term sick leave. There was also one vacant band 6 post and two vacant band 2 posts. We noted that nursing staff turnover for diabetes and endocrinology trust wide was particularly high at 35.14%. Staffing levels on Ash ward had been flagged as an issue on the risk register and measures such as increased matron focus and presence and a three times daily review of nurse staffing and skill mix had been implemented on the ward. Across the hospital, the recruitment of nurses from Italy and the Philippines had been undertaken. English classes were provided by the trust for these staff. Two consultants interviewed were both complimentary about the nursing staff and the staffing reorganisation that they had implemented.
- Staff on Fern and Ash wards reported that bank and agency staff were used on a daily basis to fill gaps in the nursing rota. Rates of agency and bank usage for these specialities were indeed amongst the highest in the trust. Trust wide, between 19.9% and 21.8% of nursing shifts in diabetes and endocrinology services were filled with bank or agency nurses between March 2016 and August 2016. This figure was ranged between 17.9% and 23.7% for care of the elderly wards in the same period. Wherever possible, senior staff tried to fill shifts using regular bank or agency staff, or asked their permanent staff to swap shifts to ensure that there was an appropriate skill mix on each shift. Induction checklists were used to orientate new bank or agency staff to each ward. Some nursing staff told us that some agency nurses were not appropriately skilled to care for patients, which meant extra responsibility fell upon them. Issues with agency nurses were escalated to ward managers, who fed this back to the nursing agency and asked them not to supply these nurses again. Sometimes, staff were moved from other areas in order to fill staff shortages on these wards.

Medical staffing

- Compared to other trusts, there was a greater reliance on junior doctors across both King George and Queen's hospital. Medical staffing was made up of 33% consultants (against a 37% national average), 9% middle career doctors (against 6% nationally), 23% registrars (against 36% nationally) and 35% junior doctors (against 21% nationally).
- Locum usage for medical staff was generally high across the trust, especially in some specialities. In

stroke services, rates of locum usage ranged between 18.4% and 34.5% for the period of March 2016 to August 2016. In the same period, locum usage in care of the elderly services ranged between 15.6% and 24.3%. Both the reliance on locum doctors and the inability to provide timely consultant senior medical input across both sites in specialist medicine were identified as issues on the corporate risk register. Advance reviews of rotas, sharing medical staff between sites, ongoing recruitment and a reduction in outpatient activity (to free up consultant time) had all been agreed as actions.

- On Gentian ward (gastroenterology and care of the elderly), locum registrars and junior doctors were heavily used, with only one trust junior doctor in post. One patient that we spoke with commented on the lack of continuity and familiarity with doctors in charge of their care. The medical assessment unit (MAU) did not have a stable consultant at present, relying on locums. Nursing staff commented that this was difficult as each consultant had a different way of managing patients. Beech ward had consultant cover two days per week and at other times was staffed by a registrar and a junior doctor.
- Lack of consultant geriatricians was highlighted as a risk by medical staff on Fern ward. Only three consultants covered the rota here and there was a reliance on locums, who specialised in general medicine rather than geriatrics. There were some gaps in the rota for registrars too. Staff therefore found some shifts on-call to be very busy. This shortage of geriatricians was a national issue and the trust was looking into recruiting more specialist nurses in areas such as falls and dementia care to fill this gap.
- Other wards such as Gardenia did not use locum consultants and had seven-day consultant cover, with ward rounds for cardiology patients taking place on Saturdays and Sunday reviews if necessary. Additional cover for the medical side of the ward was provided by a ward-based consultant, registrars and junior doctors. There was one vacant post for a junior doctor position.

Major incident awareness and training

- There was an up-to-date emergency preparedness policy available on the electronic system. Staff had awareness of what actions they would take in the event of a major incident, including a fire. An empty ward on site was used to practice fire safety drills on a weekly basis. Staff also described training that they had undertaken which detailed what they should do in the event of a terrorist incident and how they should evacuate their ward, which was described as 'very useful'.

Are medical care services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- Despite improvement since our last inspection in March 2015, there was still a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- Fluid charts were not always filled out and some patients did not like the food, or found it hard to eat.
- For non-elective admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine. Patient outcomes in care of the elderly were limited by the lack of consultant geriatricians to lead improvements within the service.
- In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures.
- In the 2015 National Training Survey, junior doctors in geriatric medicine reported lower overall satisfaction than the national average, as well as in measures such as availability of clinical supervision out-of-hours and regional teaching. Although these results had improved significantly in the 2016 survey, some issues still remained.
- There was a lack of effective seven day working across the hospital. We found there was a reliance on locum consultant cover out-of-hours and that allied health professionals worked only core office working hours during the week, with no cover at weekends. The pathology service was understaffed and unable to provide effective cover out-of-hours.

- There were issues with two out of seven sets of the Deprivation of Liberty Safeguards (DoLS) documentation that we reviewed whilst on inspection. In one set of notes, there was no official extension to the urgent authorisation present in the notes of a patient waiting for a best interests assessor to review them (this should usually occur in seven days). The trust confirmed that the extension had not been printed out and placed in the patient file, as per procedure. In another, there was no documentation or record of a DoLS application in the medical or nursing notes, although this was found later by senior staff.

However:

- The trust had updated all of their local policies since the last inspection, and these were regularly reviewed.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement. Staff of all levels told us that these led to meaningful change across the service.
- Pain was assessed and well managed on the wards, with appropriate actions taken in response to pain triggers. There was a dedicated hospital pain team.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. Actions had been taken to improve the service in those measures where they were underperforming.
- For all specialties apart from geriatric medicine, the trust scored above the national average for most measures in relation to first year medical doctors in training (2015 National Training Survey).
- The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals. Staff were satisfied with the quality of the appraisal process. The trust was supporting nurses with the revalidation process.
- There was evidence of effective multidisciplinary working within wards and across departments. All members of staff felt valued and respected.

Evidence-based care and treatment

- Trust policies were current and referenced according to national guidelines and recommendations. These were accessible through the trust intranet for all staff that had electronic access. All policies sampled were up-to-date.
- Unsatisfactory compliance with National Institute for Health and Care Excellence (NICE) guidance had been identified as a risk on the corporate risk register in 2014. A number of measures had been put into place to improve compliance, such as a monthly trust wide NICE guidance implementation committee. This reviewed current practice and developed action plans to ensure compliance with the latest NICE guidance. As of October 2016, the risk register still showed that there was a backlog of NICE guidance that was awaiting confirmation of compliance.
- Patient assessments were based on national tools, such as the Malnutrition National Screening Tool (MUST) and the Braden scale for predicting pressure ulcer risk. Care pathways based on national guidance were in place for conditions such as sepsis, stroke and pressure ulcers. Staff showed awareness of these care pathways and we saw evidence of effective treatment plans in nursing and medical records. For example, therapists on the stroke rehabilitation unit told us they were meeting the requirement of NICE guidelines for 45 minutes of daily therapy input per patient.
- There were examples of recent local audits that had been completed on the wards. These included cleanliness and documentation audits, as well as topics identified for improvement locally, such as catheter care. Senior staff visited other wards or departments to ensure objectivity in their completion. Results of these audits and any learning were shared with staff in daily safety huddles. Some senior nursing staff felt that the amount of local audits created a lot of work but did lead to positive change.

Pain relief

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. Nursing notes

showed that the numeric rating scale (NRS) was the most commonly used and nursing staff conducted a pain assessment using this tool with each comfort round undertaken (frequency varied on the acuity of the patient). The visual analogue scale (VAS) and nonverbal pain indicator checklists were used to assess pain in those with communication difficulties. Additionally, there was a detailed pain assessment chart based on the World Health Organisation (WHO) stepladder for patients in acute or chronic pain.

- Appropriate actions were taken in relation to pain triggers to make patients more comfortable. We saw examples in the records of pain control managed with PRN (pro re nata or administered as required) pain relief. Patients that we spoke with were generally happy that their pain was well controlled.
- Pain management and symptom control were discussed daily in the nursing handovers, ward rounds and huddles. Patients could be referred to the dedicated hospital pain team, who offered advice and support to patients who were experiencing pain because of their treatment or illness. The team worked Monday to Friday 8.30am - 4.30pm and Saturday 9am - 1pm.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we saw. When screening indicated a risk, staff took appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to a dietitian.
- Dietitians attended multidisciplinary team (MDT) meetings and contributed to discussions regarding appropriate nutrition and hydration. The speech and language therapists worked closely with the dietitians to establish the food and liquid consistency a patient may require if a patient had difficulty swallowing. Assessments and advice from dietitians and therapists were seen in the notes we examined.
- On some wards, stickers were used on patient boards to detail dietary requirements such as specialised diabetic, finger food or puree diets. We observed 'red trays' were in use, which alerted staff to patients who required support to eat. Adapted cutlery was available for those who needed it. Protected mealtimes were in force, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions. These had been introduced to minimise other activities on the wards and to ensure adequate support was provided to patients.
- Fluid charts were completed for patients identified as at risk of dehydration and regular mouth care was carried out to ensure their comfort. In the majority of applicable cases, these were correctly completed, but we saw two instances where no fluid intake had been recorded, despite the fact that patients had been drinking fluids. In documentation audits carried out between June and August 2016, fluid input and output total were not recorded accurately in the majority of cases. Staff told us that hospital had recently introduced smaller size water jugs in response to feedback that many patients could not lift the heavier large jugs.
- Three patients we spoke with did not like the food, calling it 'distasteful' and 'hard to eat'.

Patient outcomes

- At King George hospital, the standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate. However, for non-elective admissions, the standardised relative risk of readmission was higher, particularly for geriatric medicine. A care of the elderly consultant told us that the service was working hard to improve this situation and had seen positive changes, but that this was limited by the lack of consultant geriatricians to lead improvements within the service.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. In 2013/14, King George's hospital scored better than the England average for three of four indicators relating to diagnosis and initial management of the type of heart attack measured by the audit. Patients admitted to cardiac unit or ward

reached 75.6% (against an England average of 55.6%) and patients that were referred for or had an angiograp hy (including after discharge) sat at 82.1% (against 77.9% as an inpatient and 80.3% after discharge across England). However, only 79.1% of patients were seen by a cardiologist or a member of their team, against 94.3% of patients across England. There was also no data submitted to measure episode to treatment time and insufficient data submitted to reach conclusions regarding unadjusted mortality rates for these patients. Overall, the hospital's performance in this audit had declined since the previous year. The trust could not provide an action plan devised as a result of this audit.

- In the National Heart Failure Audit (2013/14), the hospital performed equal to, or better than, the England average in six out of 11 measures. This again showed an overall decline in performance from the previous year when measured against the England average, when it performed better on seven measures overall. Areas where the hospital performed worse included: cardiology inpatient care (40% against an England average of 49%), discharge planning (75% against an England average of 86%) and prescription of angiotensin-converting enzyme inhibitors on discharge (49% against an England average of 72%). Areas where the hospital performed better included: input from a consultant cardiologist (73% compared an England average of 60%), input from a specialist (95% compared to 78% across England) and referral to cardiology follow-up (61% against an England average of 54%). In response, the trust planned to revise the workforce to include a new consultant, specialty doctor, and heart failure specialist nurse. They also planned to improve data submission to the next audit to provide more reliable results.

- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators, including staff knowledge of diabetes (71.2% against an England average of 65.5%) and staff awareness that a patient had diabetes (85.27% against an England average of 84.33%). Since the previous audit, the hospital had introduced a training programme relating specifically to diabetes and insulin regimes. The hospital performed worse than the England average for seven measures, including foot risk assessment, management errors (30.3% compared to 23.94%) and insulin errors (27.27% compared to 22.6% across England). Senior pharmacists told us of plans to set up an insulin incidents group to address this issue. Delayed diagnosis for patients with diabetic foot conditions due to lack of a one-stop podiatry service had been identified as an issue on the risk register and the division were in the process of agreeing funding for this at the time of inspection. It was also recognised that the trust do not currently have a standard protocol/process for managing patients admitted to the wards who were already on an insulin pump, which does not comply with NICE guidance. An action plan to train staff and devise a pathway was underway, with a review date of November 2016.

- In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures. Only 78.7% of patients were seen by a nurse specialist (against an expected standard of 80%). Only 80.9% were discussed in a multidisciplinary team (MDT) meeting (against an expected standard of 95%). Only 64% received a pathological diagnosis (against an expected minimum standard of 75%). These shortfalls are problematic as there is an association between clear diagnosis, access to nurse specialists, discussion by the MDT and subsequent receipt of anticancer treatment. Detailed action plans had been put into place to improve patient outcomes in this area. For example, interactions with primary care had been a focus to improve diagnostic waiting times, specialist nurses had been recruited and additional MDTs had been introduced. Further work was being done to introduce a nurse-led triage system and meet national cancer treatment indicators.

Competent staff

- There were reliable arrangements in place for supporting and managing new staff, including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies. The trust ran a nurse preceptorship programme that included five study days over the course of 12 months. These sessions covered topics such as communication, teamwork and effective delegation, medicines management and safe practice. One newly qualified band 5 nurse told us that these

sessions not only taught her new skills, but also provided a space in which she could share her experiences with other new starters. Each new nurse had to meet regularly with an identified mentor and complete a reflective log.

- Junior doctors told us they were supported to learn, with access to effective teaching. The care of the elderly consultants, although stretched, told us they had worked hard recently to ensure that junior doctors were released two afternoons per week for teaching sessions. The National Training Survey monitors junior doctor experiences of education. In 2015, the trust scored above the national average for most measures in relation to first year medical doctors in training, but fell short regarding access to educational resources. When considering geriatric medicine as a speciality, junior doctors reported lower overall satisfaction than the national average, as well as in measures such as availability of clinical supervision out-of-hours and regional teaching. Although results had improved considerably in 2016, some of these issues still remained.
- Most staff told us they had received an appraisal in the last 12 months to assess their continuing professional development (CPD) needs and set realistic and achievable goals. Senior staff told us that some data relating to appraisals had been lost in the transfer to the new electronic system. Appraisals data provided by the trust indicated that between 70.9% and 81.7% of staff had received appraisals between April 2016 and September 2016, with one anomaly of 18.3% in diabetes and endocrinology (falling from 84.3% in the previous reporting period). Staff reported they were generally happy with the new appraisal system and process, which had improved access to CPD opportunities. Staff met with their manager after six months for a review of their CPD and to measure progress against any set goals. They had opportunities to undertake personal development opportunities to enhance their skills and were able to give examples of further study days they had completed, such as dementia awareness, care of the critically ill patient and mentorship training. The trust scored higher than the national average for staff satisfaction with the appraisals process and overall quality of appraisals in the NHS staff survey 2015.
- There were seven practice development nurses working across both sites, who were responsible for identifying training needs and delivering a sustainable educational programme to improve the delivery of patient focused services amongst nursing staff. Most wards also reported link roles for areas such as dementia, infection control and falls. These link nurses attended in-house update days in their subject and fed new developments and ideas back to the rest of the ward team.
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The trust had run open sessions around what the process involved and how to collate portfolio evidence. Specific training sessions had been given to those who may be expected to act as confirmers to junior nursing staff. Nurses we spoke with felt supported with the revalidation process. Since April 2016, when the process came into effect, 184 nurses across the trust had successfully completed this. Only one nurse had failed to successfully revalidate.
- Since 2014, doctors have been required to undertake an annual appraisal as part of the 'revalidation' programme for their professional registration (General Medical Council, 2014). The trust provided us with information about consultants working in different specialties across the trust. In acute medicine, 87.5% of medical staff had received appraisals in the last year. In specialist medicine, 91.5% of staff had received an appraisal.

Multidisciplinary working

- All relevant professionals were involved in the assessment, planning and delivery of patient care. The care records that we examined confirmed active involvement from health professionals of all disciplines where appropriate, including appropriate referrals to specialist nurses or teams (such as the diabetic nurse or tissue viability service). Each ward had a multidisciplinary team (MDT) meeting which included doctors, nurses, occupational therapists, physiotherapists and other allied health professionals (AHPs) as appropriate.
- Daily ward meetings were held on most of the wards we visited. These were called 'board rounds' and they

reviewed discharge planning and discussed future actions for those people who had complex factors affecting their discharge. Dedicated discharge coordinators worked with ward staff to identify any patients with ongoing care needs and link them in with community teams and social services prior to discharge. A daily safety huddle also took place to discuss and update the MDT on patients' progress.

- All members of the MDT reported feeling valued and respected. Doctors and nurses were complimentary about the support they received from one another and the wider team. A newly qualified nurse described the doctors on her team as 'kind' and described how they took the time to teach her about conditions and guide her in management of patients. Although there was one vacancy in the occupational therapy team for Beech ward, staff did not report any problems with referral or access to the team.
- The trust had introduced Schwartz rounds across both hospital sites to share working practices and increase support amongst staff of different disciplines. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke with had varying awareness of these sessions.

Seven-day services

- Most wards relied on locum on-call consultant cover out-of-hours, on evenings and at weekends. Junior doctors and nurses told us on-call consultants were quick to respond and they usually arrived on site within 30 minutes. However, only staff on Gardenia ward told us about consultant-led ward rounds on a Saturday.
- Most teams worked normal office hours. For example, the speech and language therapists were available on the wards Monday to Friday 8.30am – 4.30pm, and dietitians worked core hours of Monday to Friday 9am – 5pm. Occupational therapists (OTs) worked and physiotherapists worked core weekday hours 8.30am – 4.30pm, but provided an on-call service at weekends if required.
- Pharmacy services were available 9am – 5pm on weekdays, with a late service that ran until 6.15 pm. The pharmacy discharge team worked alongside the main service on weekdays, between 11am and 4pm. Weekend cover was provided on Saturdays between 9am and 2pm and on Sundays between 9am until 12pm. An on-call service, shared with Queen's hospital, was available out-of-hours. Nursing staff believed that this service was sufficient, as long as you ordered any urgent medications on Friday. Pharmacy staff had also developed measures to help nurses, such as a 'can't find a medicine' flow chart, which instructed nursing staff what to do when medicines were not available on their ward.
- Diagnostic imaging provided a 24-hour, seven-day service with a combination of extended days and on-call cover. CT and MRI ran extended days during the week and at the weekend. Staff reported no issues with accessing diagnostic testing out-of-hours.
- Pathology services were unable to provide an adequately staffed service outside of the core working hours of 9am to 5.30pm, Monday to Friday. Outside of these hours, existing staff provided a service on a voluntary rostered basis, which meant staffing fluctuated. Although pathology services aimed to return test results to the wards within 60 minutes, this was not always possible. The issue had been added to the corporate risk register and a staffing structure review and ongoing recruitment was underway.

Access to information

- There were sufficient computers available on all of the wards we visited, which gave staff access to trust information, protocols and policies. Paper copies of key policies were also available on the wards, although many of these were not the latest version.
- Clinical staff told us they had access to current medical records and diagnostic results such as blood tests and imaging to support them to safely care for patients. Admission documents and assessments were recorded in one booklet, which was kept with nursing records by the patient bedside. Patient observations were also maintained at the patient's bedside to ensure that they were easily accessible when being reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). The majority of staff we spoke with were aware of the key principles surrounding capacity assessments, best interests meetings and who they would contact for support and advice. They were able to give examples where DoLS applications had been made, such as the use of mitts to prevent confused or unconscious patients from pulling out nasal tubes.
- There was a trust lead for DoLS, based on the ground floor of the hospital, who provided support and training to staff as necessary. We saw evidence that they regularly emailed senior staff to remind them of the key issues surrounding capacity, and provided additional training around topics such as independent mental health advocacy and the MCA itself. This was now part of mandatory training, with 95.1% of nursing and medical staff having completed this training within the last year.
- Whilst all seven assessments we reviewed clearly recorded specific decisions and the reasons for the judgment made, there were some issues with some of the documentation reviewed. On Beech ward, there was no official extension to the urgent authorisation present in the notes of a patient waiting for a best interests assessor to review them (this should usually occur in seven days). When we asked staff about this, they told us that this was the job of the safeguarding team, who would hold the paperwork centrally. The trust confirmed that the extension had not been printed out and placed in the patient file, as per procedure. There was another patient on Gentian ward, who had previously been subject to a DoLS application, which had been lifted. There was no documentation or record of the application in the medical or nursing notes. This was raised with the nurse in charge, who managed to find the application after some time.
- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment, which we saw evidence of in patients' notes. We observed staff gaining consent from patients before giving routine care and treatment, such as washing or adjusting their position in bed.

Are medical care services caring?

Good

We rated caring as good because:

- Patients were cared for in a caring and compassionate manner by staff throughout their stay. Most medical wards performed in line with the national average in the NHS Friends and Family Test (FFT).
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Psychological support for patients was easily accessible and timely. Patients were routinely assessed for anxiety and depression on admission.
- The chaplaincy team offered comprehensive spiritual support to all patients, regardless of religious affiliation.

However:

- The trust performed slightly below the national average in the National Cancer Inpatient survey 2015.
- Some patients and relatives felt that more could be done to involve them in their care, especially surrounding discharge.

Compassionate care

- Staff consistently treated patients with dignity and respect. Nurses and doctors introduced themselves to patients and sought permission to enter their bed space. We saw that staff checked how patients preferred to be addressed and explained any procedures they were about to undertake, gaining clear verbal consent. Ward staff drew curtains around bed bays when privacy was needed, such as when a patient was using a commode.
- Interactions between staff and patients were positive across the hospital. Staff were warm and caring, with a compassionate and sensitive manner. Patients described how the nursing staff were "kind" and "very helpful", making sure they were always comfortable and their needs were met. One patient on Gentian ward commented that the nurses were, "always friendly" and that, "you never get a rude nurse…

sometimes I just don't know how they do it." Although patients on some wards recognised that nursing staff were stretched, most insisted that this did not affect the service they received and that nurses always, "did their best". We observed that call bells were usually answered promptly, in line with the majority of feedback we received from patients. One patient was unhappy with care that she had received in the medical assessment unit (MAU), where they alleged they had to wait over 20 minutes for their call bell to be answered. We could not find any evidence that this was widespread.

- We saw 'thank you' cards from patients and relatives displayed on Fern ward. Comments included, "all of your smiles, kind words, happy faces and caring goes a long way towards a patient's recovery", and"your caring, politeness, jovial sense of humour makes it so much more pleasant for patients".
- The NHS Friends and Family Test (FFT) is a national initiative to gain feedback from patients following their admission to hospital. The trust had a higher response rate than the England average, with most wards scoring recommendation scores comparable to the England average of 96% (May 2016). Between March and May 2016, Gardenia ward scored 91-94%, Gentian ward scored 94-100% and Fern ward scored 87-100%. In July 2016, Beech ward scored only 77.8%, but only nine patients took part. The ward scored highly in regards to dignity and respect (4.7 out of a possible five) but only 3.7 for communication (from medics or AHPs). In August 2016, Gardenia ward scored highly on all measures, with all patients reporting that they were either 'extremely likely' or 'likely' to recommend the ward. Individual comments reported that it was a "very happy ward" and staff were "always willing to help".
- The trust performed mostly in line with, or slightly below, the national average in the National Cancer Inpatient survey 2015. A total of 1,033 respondents were asked to rate their care on a scale of zero (very poor) to 10 (very good). Respondents gave an average rating of 8.5 (within the expected range), and 84% of respondents said that, overall, they were always treated with dignity and respect when they were in hospital.

Understanding and involvement of patients and those close to

- Most patients told us they felt involved in planning their care, and in making choices and informed decisions about their future treatment. The majority of patients we spoke with knew what their prescribed medications were for and felt that doctors were providing them with regular updates on their condition and progress. One patient on the MAU had been shown how to detach their drip stand so they could mobilise and use the toilet independently.
- We observed staff involving patients and those close to them during assessments on the ward giving them time to ask questions or clarify comments. We observed a therapy assessment on Beech ward, where the therapists involved the patient as much as possible and encouraged him to maintain his independence, whilst keeping him safe from the risk of falls.
- In the National Cancer Inpatient survey 2015, 74% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment. A further 75% of respondents felt they were given complete explanation of test results in an understandable way (within the expected range) and 52% of patients were definitely told about side effects that could affect them in the future (against a national average of 54%). A further 89% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital (against an expected lower limit of 91%). Action plans had been put into place to improve these results in all areas where expected standards had not been met. These included improving information sharing in MDTs, reviewing written patient information leaflets, communication training for staff and improving collaborative working with community providers and GPs.
- Some patients and relatives felt that more could be done to involve them in their care, especially surrounding discharge. One patient in the MAU had been in hospital for some time and had discussed self-medication, but this had not been actioned. Another patient on Gardenia ward felt that their treatment pathway was unclear and the results of their diagnostic tests had not been explained to them

properly. A relative on the same ward was concerned that doctors were discussing the discharge of her mother but her family did not feel the patient was ready to go home. She was concerned that no one was explaining what help would be available in the community and felt frustrated. Similarly, a patient's relative on Beech ward was unclear of the discharge plan going forward and was unsure about what would happen when his wife returned home, despite her being in hospital for some weeks. FFT scores for Beech ward in July 2016 showed a score of only 3.9 (out of a possible five) for information provision and four (out of five) for patient involvement.

Emotional support

- Most patients we spoke with were very positive about the support they received from members of the MDT. The hospital had access to specialist nurses that could offer additional support and advice for example, for patients with chronic conditions such as diabetes, or complex diseases such as cancer. In the National Cancer Inpatient survey 2015, 92% of respondents said that they were given the name of a specialist nurse who would support them through their treatment. When asked how easy or difficult it had been to contact their specialist nurse, 81% of respondents said that it had been 'quite easy' or 'very easy' (against an expected lower limit of 82%).

- Patients were assessed for anxiety and depression on admission, with individual items scoring between zero and three, depending on their presence. Psychology input for stroke rehabilitation patients was accessed through the team based at Queen's hospital. Patients could either be taken across in hospital transport with an escorting nurse, or a member of the team would review them on the ward if this was not possible. Other wards were able to access support from the psychiatric liaison team and had access to agency mental health nurses for those patients who required 1:1 care. Staff gave examples of recent occasions where they had required assistance from mental health nurses and tried to employ the same agency nursing staff to achieve continuity of care for the patient at this difficult time. Psycho-oncology services and complementary therapies were both available on-site, as well as alcohol liaison and counselling service for inpatients. However, nursing staff that we spoke with had not received any training specific to caring for patients with mental health conditions.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients were not always able to be located on the specialist ward appropriate for their condition, although management of these patients had improved since the previous inspection. The number of patients moved four or more times per admission had increased. In some wards, such as Ash, Gentian and Gardenia ward, bed moves were consistently occurring out of hours (between 10pm and 6am). However, the trust later informed us that the data demonstrating an increased number of bed moves was incorrect as they had been counting moves to other departments within the hospital as ward moves.

- Environments on some wards were not ideal, with high levels of noise and heat observed and reported. There was a lack of bedside televisions or radios across the wards, which some patients reported made them feel isolated and bored.

- The trust had identified that the pathways for patients with cancer were not correctly managed and that there was poor communication with tertiary centres, which caused delays with patients requiring tertiary treatment/diagnosis at other specialist hospitals. This issue had been added to their risk register in August 2016 and was currently being monitored by senior managers. Actions to improve this had already been implemented, such as a weekly call with tertiary centres to identify issues at patient level and seek resolution.

- The trust was not meeting 18-week national indicators for non-urgent referral to treatment (RTT) times.

Medical care (including older people's care)

- NHS England suspended endoscopy screening invitations to the trust for eight weeks from July 2016. There was a temporary risk of delayed diagnosis of bowel cancer due to inability to provide a full screening service to the local population.
- Staff across the hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place. The specialist medicine division was currently working on an early discharge flow programme to address excessive lengths of stay.
- Patient information leaflets were not standardly available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner. There were no leaflets detailing how to access PALS and make a formal complaint on Gentian ward at the time of our inspection.

However:

- Diagnostic waiting time indicators were met by the trust every month between May and August 2016, meaning over 99% of patients waited less than six weeks for a diagnostic test.
- Much work had been done since the previous inspection to ensure that discharges were not delayed due to take home medications. Ward-based pharmacists helped to facilitate discharges in areas where they were available. There was also a pharmacy discharge team who worked 11am to 4pm to weekdays.
- People living with dementia received tailored care and treatment. Care of the elderly wards had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help. Patients living with dementia were nursed according to a specially designed care pathway and were offered 1:1 nursing care from healthcare assistants with enhanced training. A specialist dementia team and dementia link nurses were available for support and advice.
- Support for people with learning disabilities was available. There was a lead nurse available for support and advice. Staff made reasonable adjustments for patients with learning disabilities and there were easy read information leaflets available to explain treatments and support during their stay in hospital. There was a monthly safeguarding and learning disability operations group.

Service planning and delivery to meet the needs of local people

- There was a local representatives panel, held bi-monthly, to give updates to stakeholders including Healthwatch and local councillors. Minutes indicated that service planning and delivery were a key component of the discussions within these meetings.
- Some of the facilities and premises were appropriate for the services planned and delivered. For example, elements of the care of the elderly wards had been specifically designed to meet the needs of patients living with dementia. The wards used a colour scheme that identified the bays, introduced 'orientation clocks' and improved signage, allowing patients to find their way to toilets and shower rooms easily. There were plans to introduce clear signage, contrasting coloured areas and large clocks to other areas of the hospital.
- Some of the patients we spoke with commented that the wards could be very noisy at night. We observed that Fern ward was quite unsettled in the morning, with lots of corridor traffic and high noise levels. This improved in the afternoon, although patients we spoke with confirmed that this level of disruption was not unusual. One patient that we spoke with was very frustrated as she was sharing a bay with other patients living with advanced dementia. The patient told us she unable to rest or sleep at night and that nurses focused their care on other "noisy" patients and said, "if I made more noise I would get more attention". Patients also reported that the ward was very hot and there were not enough fans to combat warm temperatures in the summer. Although the trust had installed Wi-Fi across both hospital sites, there was a lack of bedside televisions or radios in the wards. Some patients without access to internet compatible devices told us that this made them feel isolated and bored.

- The trust had identified that the pathways for patients with cancer were not correctly managed and that there was poor communication with tertiary centres, which caused delays with patients requiring tertiary treatment/diagnosis at other specialist hospitals. This issue had been added to their risk register in August 2016 and was currently being monitored by senior managers. Actions to improve this had already been implemented, such as a weekly call with tertiary centres to identify issues at patient level and seek resolution.

Access and flow

- There were daily bed management meetings attended by senior staff to plan patient admissions, transfers and discharges. Care pathway organisers helped to facilitate patient flow throughout the hospital.
- Patients were not always able to be located on the specialist ward appropriate for their condition, although ward staff told us that management of these patients had improved. Information provided by the trust showed there was a shortage of medical beds and a number of patients were placed on wards that were not suited to meet their needs (also known as medical outliers). The specialist medicine division had highlighted this as an issue on their risk register, identifying that they were unable to place their patients in the correct speciality, resulting in outliers.
- Data demonstrated that 225 (3% of) inpatients were moved four or more times per admission between September 2015 and August 2016. This had increased since the previous inspection. In some wards, such as Ash, Gentian and Gardenia ward, bed moves were consistently occurring out of hours (between 10pm and 6am) with between 55 and 60 patients moved in these times during August 2016. A patient on Gardenia ward told us that they had been transferred between multiple wards during their nine day stay. However, the trust later informed us that the data demonstrating an increased number of bed moves was incorrect as they had been counting moves to other departments within the hospital as ward moves.
- At King George hospital, the average length of stay for all elective and all non-elective patients was higher than the England average, with the exception of non-elective patients in geriatric medicine.
- The bed occupancy rates between April and August 2016 for King George's hospital ranged between 83.4% (August) and 88.4% (May).
- The trust did not submit any referral to treatment time (RTT) data to NHS England in the reporting period (June 2015 – May 2016), for unknown reasons. The NHS Constitution gives patients the right to access services within maximum waiting times. This is normally 18 weeks for non-urgent conditions. The trust was not meeting this national indicator, with data provided directly indicating that between 64.3% and 73.7% of patients being treated within 18 weeks of original referral between September 2015 and August 2016.
- In the trust's annual report 2015/16, they reported that 96.1% of patients with a diagnosis of cancer received their first treatment within 31 days of decision to treat (against a national indicator of 96%). In 2016, performance against the 31-day national indicator continued to be good, achieving 100% for every month between March and July, apart from in April, when only 83.4% of patients were seen. In the same annual report, the trust reported that only 74% of patients were receiving their first treatment from the initial GP referral within 62 days (against a national indicator of 85%). This continued to be an issue in 2016, with between only 25% and 80% of patients meeting the 62-day national indicator between March and July. The trust was aware that it was failing to achieve this national indicator and attributed this to poor pathway management for specific tumour groups (urology, upper GI and colorectal), capacity and workforce issues, in addition to diagnostic tests occurring too late in the pathways. An action plan was devised to improve this, which included the engagement with partners via the London Cancer Vanguard programme to escalate issues and delays, regular review of capacity with additional clinics being run regularly and a recruitment plan being put into place. A cancer programme board monitored performance on a weekly basis and strengthened tracking of all patients on a 62-day pathway.

- Diagnostic waiting time indicators were met by the trust every month between May and August 2016, meaning over 99% of patients waited less than six weeks for a diagnostic test. In April 2016, the trust fell short of this, achieving 98.4%.
- The trust had identified a risk of delayed diagnosis of bowel cancer due to inability to provide a full screening service to the local population. NHS England suspended endoscopy screening invitations to the trust for eight weeks from July 2016. This was due to staff leaving the service and was added to the risk register in the same month. An action plan had been put in place to mitigate this. A 0.2 whole time equivalent (WTE) locum colonoscopist was employed to run an additional list and provide backfill cover when substantive consultant was on leave. By October 2016, all substantive staff were in post and invitations were restarted, with 33% of invitations being sent out.
- The medical assessment unit (MAU) was sometimes unable to function effectively because it was not able to move patients promptly to other speciality wards within the hospital due to lack of bed availability. The average length of stay on MAU was intended to be 48-72 hours but this often meant patients stayed on the ward for a week or longer.
- Staff across the hospital told us they could not always discharge patients promptly because community hospital beds were not available or suitable ongoing care arrangements or equipment were not in place. On Beech ward, nursing staff told us that this had recently become even more problematic because of the closure of an acute stroke unit in another London hospital, so there were not the same community links for these patients. A Joint Assessment and Discharge team, which included both nurses and social workers, worked together with ward staff and patients whose discharges were delayed or complex. The specialist medicine division was currently working on an early discharge flow programme to address excessive lengths of stay, which was included as an item on the divisional risk register in August 2016.
- There was a discharge lounge, where patients awaiting transport for discharge were transferred in order to ease the pressure of beds on the wards. Patients arrived at the discharge lounge with their take-home medications and were usually collected by transport by 8pm at the latest. Ward-based pharmacists helped to facilitate discharges in areas where they were available. There was also a pharmacy discharge team who worked 11am to 4pm to weekdays. Nursing staff were encouraged to order any medications for anticipated discharges as soon as possible. Some wards had introduced a named nurse responsible for discharge planning to ensure this took place.

Meeting people's individual needs

- On most wards we visited, there was a 'good to talk' board, which included information on how to contact the patient advice and liaison service (PALS), language services, chaplaincy support and how to provide informal feedback. There were also boards on every ward that explained who different key staff were and included pictures of the different staff uniforms in use, explaining what role each one signified.
- The medical inpatient service aimed to ensure that support was available for patients with complex needs. A training course was being piloted that included training in areas such as falls prevention, caring for people living with dementia and mental capacity. One of the matrons told us how she attended this training and then shared her knowledge with other staff on Fern, Gentian and Erica wards.
- Staff used a cognitive assessment tool to identify patients with memory issues on admission. A joint delirium clinic with a psychiatrist from another trust also took place at the Queen's site to enable the rapid assessment of patients who had recently become confused. This determined whether the cause of the confusion was dementia or, something more easily treated, such as a urinary tract infection. A memory clinic had been introduced at King George's hospital, to provide assessment, diagnosis, treatment and therapeutic interventions to those experiencing memory loss.
- Wards used a butterfly symbol on patient information boards to indicate that a patient was living with dementia. Patients living with dementia were nursed according to a specially designed care pathway and were offered 1:1 nursing care from healthcare assistants with enhanced training, who provided

stimulation and company. Family members and carers were encouraged to be involved in their care as much as possible and 'this is me' booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient. Red trays at meal times were used to alert nursing staff the patient may require extra help and finger food was available for these patients. Staff had received in-house training on caring for people living with dementia. All staff we spoke with were aware that these patients needed extra support and were able to describe how they would provide them with person-centred care. A specialist dementia team (based at Queen's hospital) and dementia link nurses were available for support and advice.

- There were dementia carers coffee mornings, facilitated by the dementia team, to provide information and support to carers and relatives of patients living with dementia. The trust worked with external organisations and charities to provide further support and advice to patients and their families upon leaving the hospital.
- Support for people with learning disabilities was available. There was a lead nurse available for support and advice. Staff worked collaboratively with the carers of learning disabilities patients to meet their individual needs. Staff made reasonable adjustments for patients with learning disabilities such as open visiting and allowing carers to stay overnight. There were easy read information leaflets available to explain treatments and support their stay in hospital. Nursing staff also told us that hospital passports were used for patients with learning difficulties, but could not locate this in the file of a patient currently on one of the wards.
- There was a monthly safeguarding and learning disability operations group, where any issues around caring for patients with learning disabilities or dementia were discussed. Regular audits were carried out around staff awareness and knowledge of caring for patients with these complex needs. The results were shared at the monthly meetings and any action points to take forward were agreed.
- Patient information leaflets were not standardly available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these. They told us that they used family members to communicate with patients whose first language was not English. There are several issues with this, such as potential unreliable information transfer, reluctance to deliver bad news and unfamiliarity with medical terminology. A patient on Gardenia ward told us that the language barrier had been a problem during their stay as they only spoke Hindi and translation services had not been effectively accessed. However, we saw one example of good practice on Beech ward, where one Chinese patient had been provided with Chinese symbols mounted on card to communicate simple messages.
- Within the catering menu there were many options to cater for those with different nutritional requirements. Menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options. However one patient we spoke to, who was vegan, told us she had not been provided with sufficient dietary options, such as dairy-free milk.
- Chaplaincy services for patients requiring spiritual support were available. There was a multi-faith chapel on-site for worship, with an ablutions room available for people from the Muslim faith. Staff said the hospital chaplains had a visual presence around the hospital and were easy to contact through the switchboard. Representatives from most major religions were available, including Church of England, Catholic, Islam, Judaism, and Sikhism.
- There was access to psychological support for those undergoing cancer treatment through the Macmillan Information Centre. All specialist nurses were also trained in level two psychology. Patients also had access to a variety of support groups classified by cancer type. In the National Cancer Inpatient Survey 2015, 75% of respondents said that hospital staff gave information about support groups (against an expected lower limit of 78%).

Learning from complaints and concerns

- Staff told us that informal complaints were dealt with at ward level. Formal complaints were handled by the Patient Advice and Liaison Service (PALS) or the

complaints department. There were leaflets throughout most wards detailing how to access PALS and make a formal complaint, although none were seen on Gentian ward at the time of our inspection.

- The acute medicine division as a whole received 122 complaints between April and September 2016. Analysis across the trust showed that the top themes of complaints were treatment, staff attitudes, security, communication and diagnosis.
- The trust reported that it was currently 100% compliant with acknowledging written complaints within three working days (August and September 2016). PALS attempted to respond to verbal complaints within five working days, but would agree a final timescale with the complainant in each individual case. The overall complaint had improved from 78.3% in July 2016, up from just 14.8% in June 2016. Minutes from clinical quality review meetings indicated that PALS responses to complaints were sometimes not timely. Between April and June 2016, only 60% of complaints were replied to within the timescale agreed with the complainant, against a trust target of 85%. For example, minutes from June 2016 indicated that 13 responses across the trust were overdue against a zero tolerance. These had been escalated to speciality managers.
- The trust conducted a survey of 159 patients that had made complaints between September 2015 and September 2016. Of these patients, only 65% of patients were satisfied with the time frame of the complaints investigation process. However, 84% of patients felt they were given an apology where appropriate and 80% of patients felt that lessons were learned from the complaint and appropriate actions were taken.
- Complaints data was discussed monthly at both the clinical quality review meeting and the patient experience and engagement group. Any themes or learning were then shared with wider staff groups through the integrated quality and safety report, team meetings and divisional newsletters.

Are medical care services well-led?

Good

We rated well-led as good because:

- The trust had developed a clinical vision and strategy and communicated this to staff of all levels, enabling them to feel involved in the development of the service.
- The governance structure had been revised to provide a greater level of accountability and oversight of risk.
- Most nursing and medical staff thought that their line managers and the senior team were supportive and approachable. The chief executive and divisional leads held regular meetings to facilitate staff engagement.
- Quality improvement and research projects took place that drove innovation and improved the patient experience. Regular audits were undertaken, overseen by a committee. The hospital facilitated a number of forums and listening events to engage patients in the development of the service.

Leadership of service

- The trust had restructured the management of the service in 2015/16, establishing six clinically led divisions, each with a divisional clinical director, divisional nurse and divisional manager. This meant that medical services fell under either the specialist or acute medicine divisions. New appointments had been made within the divisions, such as the addition of two new matrons within the specialist medicine division.
- Most staff felt positive about these changes. Junior nursing staff described their ward managers and matrons as approachable and supportive, confirming that they were available at all times for advice, even when working cross-site. A few staff commented that this could sometimes cause administrative delays, but did not directly affect patient care.
- The senior divisional leaders were described as visible and proactive by some nursing and medical staff, who told us that they were looking into areas of concern and engaging staff in the process of incremental positive change. One consultant believed his divisional leaders gave him the opportunity to be

autonomous but also offered oversight and support where necessary. Other staff were not as enthusiastic, describing them as just "okay" and believing they could be more involved in the clinical management of the hospital.

- The executive team held various regular meetings with staff of all levels. The chief nurse met with staff of band 6 and above every week to discuss challenges faced on the wards. There was also a 'breakfast with the boss' meeting, where staff of all levels could meet with the chief executive. Divisional managers also sometimes attended daily board meetings on the wards.

Vision and strategy for this service

- The trust had adopted a set of values based on their involvement with a consulting organisation, which emphasised person-centred care and an evidence-based quality improvement culture. These were now fully embedded within the service, based on the acronym 'PRIDE', which stood for Passion, Responsibility, Innovation, Drive and Empowerment. All staff we spoke with were aware of these values. Medical staff told us that the values-based approach gave them more of a sense of ownership and empowerment, changing things across the hospital for the better.
- The approach of continuous, incremental improvement was emphasised across the trust. The focus for all improvement work within the trust was the elimination of waste, the standardisation of work, mistake proofing and a methodology aimed primarily at reducing flow times and response times to patients. The goal of the trust was to become a learning organisation that engaged staff at every level. As such, this approach had been incorporated into the staff appraisal process.
- There was a five-year plan which had been developed in partnership with system leaders and organisations across north east London (with 2016/17 being the first year of the plan). This plan described how services would collectively work to deliver sustainable services to the local population, and was aligned to the emerging trust clinical services strategy. The plan involved working closely with commissioners to define and manage clinical pathways. In December 2015, the trust had conducted a stakeholder audit to identify strengths and weaknesses and find a way of working together with other organisations to improve services. For example, for diabetes, the trust was already working with commissioners to ensure a single joint service operated across both community and acute services in the region. This would mean patients could easily access the most appropriate care for them and the local health economy as a whole could manage demand. This pathway included escalation mechanisms to consultant level, in the case of deteriorating patients. The trust planned to use this as a model when tackling issues such as the national cancer treatment indicators, where the 62-day indicator was currently in breach.

Governance, risk management and quality measurement

- It was clear the service had taken steps to address some of the issues identified during our previous inspection, such as the review of serious incidents and the reporting culture surrounding these. Where risks still remained, such as the reliance on locum doctors, these issues had been added to both the divisional and corporate risk registers to be monitored. Risks were graded according to likelihood and impact. Both the acute and speciality medicine divisions had up-to-date risk registers that included mitigation and action plans. Issues on the risk registers aligned to the concerns that staff identified.
- There were several groups which aimed to improve governance and risk management across the trust. The clinical outcome and effectiveness group discussed topics such as national targets, audits, care pathways, medicine optimisation and NICE compliance. The patient safety group focused on topics such as incidents, infection prevention and control, medicines safety and safeguarding. The patient experience group discussed areas such as complaints, dementia, nutrition and volunteering. The people and culture committee examined issues such as staffing, training and equality and diversity. Discussions from these meetings all fed into the monthly quality assurance committee, which considered governance and risk management issues as a whole. However, some staff told us that this committee was often poorly attended.

- There were also regular senior nurses meetings, as well as divisional and ward meetings where risk and governance issues were discussed with a wider staff group. The frequency of these meetings varied across divisions, with some specialties or wards meeting every two weeks, and some every three months. Senior staff were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for each ward.
- The divisions had an audit calendar, which was used to monitor services and compliance against national and local standards. Nursing staff participated in local audits, and although some told us that this increased their workload, they could see how resulting information was shared amongst teams to promote improvement. There was an audit committee that met five times a year to oversee both external and internal audits.

Culture within the service

- Staff of all levels said they felt supported and able to speak up if they had concerns. Nurses told us there had been a shift away from 'blame culture', towards learning from mistakes and 'near misses'. Most felt comfortable to raise concerns with local managers, but were also aware of formal whistleblowing procedures and policy. The independent guardian service was now into its third year and helped staff to openly raise their concerns in confidence.
- Staff of all levels told us they were happy working at the hospital and felt they contributed to creating a positive work environment. All staff we spoke with spoke positively of their local teams, speaking of the positive changes that had occurred since the last inspection. They commented on improvements in nursing morale and empowerment, making the wards more enjoyable to work on and reducing stress and sickness. New starters felt supported and able to ask questions. Although the NHS staff survey results were below average for acute trusts, staff who worked across sites told us that there was a big difference in working at King George's hospital. They described the atmosphere as more friendly and relaxed than Queen's hospital.

Public engagement

- The medical service engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service. Weekly patient safety summits, run by the medical director, offered patient partners the opportunity to discuss incidents, safeguarding and other issues that affected patient care. Medical staff that we spoke with confirmed that they received minutes from these meetings via email. The trust had also introduced a patient experience and engagement group in 2015, which provided a forum for staff to engage with and receive feedback from key stakeholders including patients and carers. Listening events, held in conjunction with Healthwatch, focused on the highest number of Patient Advice and Liaison Service (PALS) enquiries and formal complaints, allowed patients the chance to ask senior management questions around issues raised. The trust produced leaflets that summarised concerns arising from these meetings and stated what had been done to address these. Other wards, such as Fern ward, invited patients to come and talk to ward staff about their experiences of care.
- In April 2016, the trust awarded the contract for delivering and reporting of the Friends and Family Test (FFT) to an external organisation. This organisation provides continuous, real-time collection, monitoring and analysis of quantitative and qualitative patient feedback. This was rolled out fully across the trust in June 2016 and at the time of inspection, online patient surveys were live. King George's hospital received 13,282 online reviews to date (as of 10 October 2016), with an average rating of five stars (out of five). Nursing staff reported that this had really helped to improve both patient confidence in the hospital and staff morale, as it helped put positive experiences in the public domain.
- The trust included patient stories as part of the corporate trust induction. A patient story, based on real life experiences from the hospital, was presented each month at the board meetings so that leaders could hear first-hand about how patients felt about the care they had received.

- There were 217 active volunteers at the end of June 2016. The roles volunteers undertook varied from welcoming patients to the hospital and helping them find their way, to chaplaincy and clerical positions. There was a dedicated volunteer of the year award.

Staff engagement

- Staff attended various ward and divisional meetings, as well as additional forums such as monthly senior sisters meetings, specialist nurse forums and non-medical prescribing forums, where appropriate. The meetings were designed to foster staff engagement, share information and drive forward improvement. Staff had been consulted on the changes taking part across the service, and for the most part, told us that they felt engaged with the service as a whole.
- The trust conducted various local surveys and engagement with the NHS staff survey which had increased to 37% in 2015. This meant that it was now almost in line with the national average (41%). In the acute medicine division, staff were satisfied with support from their immediate line management and the level of training and support they received. In fact, the quality of non-mandatory training, learning & development across the trust was rated in the top 20% of comparable trusts. In care of the elderly, staff felt satisfied with opportunities to use their skills and show initiative. They felt involved in important decisions and felt that senior managers acted on staff feedback. Communication between senior management and staff was noted to be effective. These measures had improved across most of the trust from the last survey, and staff motivation was now within the top 20% of comparable trusts.
- There were some issues in the staff survey results. Staff in the endocrinology department reported that they felt harm may be caused to the public through 'near misses' or errors they had witnessed in the last month (83% against trust average of 30%, which was in line with the national average). This was also higher than the trust average in acute medicine. In gastroenterology, staff felt that managers did not involve staff in decisions (57%) and did not act on staff feedback (53%). In care of the elderly, as well as acute medicine, discrimination and abuse from the public were also perceived as particularly high. Across the trust, the percentage of staff experiencing discrimination at work was higher than the national average, as well as those reporting bullying and harassment. The number of staff believing that there are equal opportunities for career progressed remained unchanged from the previous survey and was lower than the national average. Action plans had been developed as a result of these issues, with staff being encouraged to increase incident reporting and raise concerns at the time they happened, the development of two-way communication and an increase in forums for staff to raise concerns. There was also a focus on releasing staff to attend divisional meetings to improve communication and engagement with senior managers.
- The trust celebrated the achievements of staff by having a 'star of the month' which colleagues nominated. There were also annual staff award ceremonies, based around the trust values, which awarded staff in categories such as 'Hospital Hero', 'Working Together' and 'Pursuing Excellence'. Staff could also receive 'terrific tickets' at any time to thank staff for going above and beyond.

Innovation, improvement and sustainability

- The trust was chosen as one of five trusts in the country to be mentored by the Virginia Mason Institute (the USA's 'Hospital of the Decade') as part of a five-year improvement programme. Clinicians and leaders from the institute were teaching staff about the principles and systems that they used. The trust planned to focus on continuous, incremental improvement, focusing initially on improving the experience of the admission process (first 24 hours of care) and diagnostics, particularly the way we communicate results of investigations between clinical teams and patients.
- Most staff were positive about the involvement they had in the development of services and innovative practice. They were able to attend conferences and present papers. In care of the elderly, much work had been done in ensuring that patients living with dementia received good care. Across the trust, 12 new positions of specialist healthcare assistants (HCAs) had been instated to ensure that people with living dementia received safe and compassionate care, without relying on existing or agency nurses. Integrated case

management was now possible for care of the elderly patients, with virtual meetings with GPs and community matrons taking place. Other senior staff had submitted business cases for additional staff support. For example, on Fern ward, an advert was out to post for a band 2 housekeeper to check equipment, make sure appointments kept and get patient feedback. There was also a plan in place to bring staffing levels up to 1:7 instead of 1:8. However, a few staff we spoke with felt that there could be more of a focus on research within their department.

Outpatients and diagnostic imaging

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

Information about the service

King George's Hospital (KGH) offers a range of services and clinics for outpatients, including: general surgery, ear, nose and throat (ENT), breast surgery, cardiology, nephrology, respiratory medicine, neurology, orthopaedics, trauma, urology, opthalmology, clinical oncology, endocrinology, rheumatology, gastroenterology, general medicine, anti-coagulation, pain management, and dermatology.

The centralised appointment booking system for Barking Havering and Redbridge University Trust (BHRUT) was located at King George's Hospital.

Between March 2015 and March 2016 the Trust saw 817,013 patients in their outpatients department across two sites.

The main OPD was located near the main entrance area and was divided into further sub-waiting areas, including the phlebotomy department. Cardiology was located on the first floor and symptomatic breast services in a separate area on the ground floor.

KGH also provides a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine and interventional radiology. The service performed approximately 44,500 examinations each month across both Queens and King George's Hospital. The radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals.

Outpatient services had an action plan in place to make improvements following recommendations from the previous Care Quality Commission (CQC)

During our inspection we spoke with 12 patients and 27 members of staff. Staff we spoke with included reception and booking staff, nurses of all grades, radiologists, clerical staff, radiographers, doctors and consultants.

We observed care and treatment. We also reviewed the systems and management of the departments including the quality and performance information.

Outpatients and diagnostic imaging

Summary of findings

We found the outpatients and diagnostic imaging services required improvement.

- Outpatients and diagnostic imaging services were in transition. The strategy for these services was in development. There were a number of new senior managers who had introduced new quality assurance and risk measurement systems. However, these were not fully embedded.
- Hand gel dispensers were in situ across outpatients and diagnostic imaging but we did not observe staff or patients using them.
- The percentage of patients who did not attend (DNA) their appointment was above the England average. Staff told us they were not confident of meeting the national indicator for patients waiting over 18 weeks by their target date of March 2017. The trust's performance for the 62 day cancer waiting time was consistently below the England average. Appointments cancelled by the hospital were also higher than the England average.
- Some staff in the diagnostics and imaging team said there was a lack of clarity around their roles and responsibilities.

However , we also found:

- There was evidence of improvements in outpatient, diagnostic and imaging services. There had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016.
- Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. Lessons were learnt from incidents and shared across the trust.
- The trust had changed their patient records system and introduced the electronic patient record (EPR).
- There were appropriate protocols in place for safeguarding vulnerable adults and children. Staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.
- Patients' and staff views were actively sought and there was evidence of improvement and development of staff and services. Staffing levels and skill mix were planned to ensure the delivery of outpatient, diagnostic and imaging services at all times. All new staff completed a corporate and local induction. Staff were competent to perform their roles and took part in benchmarking and accreditation schemes.
- Medicines were found to be in date and stored securely in locked cupboards. Staff were able to describe the procedure if a patient became unwell in their department and knew how to locate the major incident policy on the intranet.
- All the patients, relatives and carers we spoke with were positive about the way staff treated people. There was a visible person-centred culture in most departments. Patients and relatives told us they were involved in decision making about their care and treatment. People's individual preferences and needs were reflected in how care was delivered.
- Work was in progress to conduct a demand and capacity analysis to enable the service to develop a model whereby the hospital could assess and effectively manage the demands on the service. The hospital was using a range of private providers to assist in clearing the backlog of appointments.
- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based. The service was monitoring the care and treatment outcomes of patients who were receiving outsourced care from providers in the private sector.
- Outpatients, diagnostic and imaging services had introduced extended clinics seven days a week to clear patient waiting list backlogs.
- There was a formal complaints process for people to use. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms.
- Most local managers demonstrated good leadership within their department. Managers had knowledge of

Outpatients and diagnostic imaging

performance in their areas of responsibility and understood the risks and challenges to the service. There was a system of governance and risk management meetings at both departmental and divisional levels.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe requires improvement because:

- The audiology room venting system was not working.
- Hand gel dispensers were in situ across outpatients and diagnostic imaging but we did not observe staff or patients using them.
- The inspection raised concerns about the diagnostic imaging department not complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Ionising Radiation Regulations 1999 (IRR99). These regulations are to protect patients, staff and the public.
- Although a comprehensive induction programme was in place for all new diagnostic imaging staff, some new staff members did not know where to find the Local Rules. Local Rules are produced to satisfy the requirements of the Ionising Radiation Regulations (IRR1999) and are designed to enable the work within the diagnostic imaging department to be carried out safely and in accordance with the regulations.

However, we also found:

- Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. Lessons were learnt from incidents and shared across the trust.
- Procedures were in place for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly. The outpatients department had introduced a decontamination room in the previous 12 months.
- The trust had changed their patient records system and introduced the electronic patient record (EPR),
- There were appropriate protocols in place for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.

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- Staffing levels and skill mix were planned to ensure the delivery of outpatient, diagnostic and imaging services at all times. The staffing issues in diagnostic imaging had been addressed from the previous report and new staff were in post. Agency staff were used to manage the workload the musculoskeletal ultrasound.
- The majority of staff had completed the required mandatory training.
- All medicines in outpatients and diagnostic imaging were found to be in date and stored securely in locked cupboards.
- Staff were able to describe the procedure if a patient became unwell in their department and knew how to locate the major incident policy on the intranet.
- The outpatients department had introduced key pad protected notes rooms for each base area, to ensure patient's information was protected.

Incidents

- The service had systems in place to ensure that incidents were reported and investigated appropriately. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system. Radiography staff informed us they were encouraged to report incidents which occurred in their working area. All the staff we spoke with were confident to report incidents via the trusts electronic reporting system.
- There was a total of 433 incidents reported between 1 September 2015 and 15 September 2016.There had been no never events and 13 serious incidents requiring investigation reported between July 2015 to June 2016 to the strategic executive information system, (STEIS).
- There were 3 open incidents on the day of the inspection in diagnostic imaging. The quality lead for the directorate showed us the categories of the incidents and how they had been assigned to a lead member of staff for further follow up. Senior staff told us they received weekly emails with updates on incidents and a timeline within which to respond.
- Incidents were monitored by the trust's risk management team for trends. The lead sent electronic incident reports to team leaders monthly.
- Incidents were standard agenda items at monthly 'incident reporting' meetings. SI investigations were sent to departmental leads prior to the meetings. The monthly were attended by a staff representative from each service area. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings. Staff told us that learning from incidents in other parts of the trust was cascaded at team meetings and huddles.
- The matron and senior sister received safety alerts and was responsible for taking action to respond to relevant alerts. This included discussion of alerts at the huddle meeting. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS).
- The outpatients department had produced written guides for staff on how to report an incident using the internet. This gave staff step by step guidance of recording and reporting incidents.
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there had been improvements in staff incident report and there was a culture of reporting incidents promptly within both the outpatients department. Incidents were audited on the trust's electronic reporting system by the risk management team.
- Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC. At the time of the inspection, there were no reported cases with the CQC for the KGH site.
- Documents related to the IR(ME)R and IRR99 regulations were held on the computer shared drive for diagnostic imaging. The local rules for KGH had not been updated since 2014 and the procedures that all employers are required to have in place when using ionising radiation had also not been updated since 2012. The documentation was difficult to locate on the computer.

Outpatients and diagnostic imaging

- There was a record of IR(ME)R training for non-medical referrers on the noticeboard in the staff area which had been put in place on the first day of the inspection. There was no record of this staff member on the electronic file for non-medical referrers.
- The last IR(ME)R audit undertaken in 2014 showed KGH was non-compliant with several requirements. The action plan had not been updated to demonstrate any progress on these issues.
- There is a contractual imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'. Staff told us the 'duty of candour' was included in the trust's safeguarding training, and they were honest with patients if clinics were running late and offered patients' opportunities to re-book appointments.

Cleanliness, infection control and hygiene

- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Personal protective equipment was readily available in all clinical areas and we observed staff using it. Alcohol gels were available outside of all clinical rooms on the outpatients department with clear signage asking staff and patients to gel their hands prior to entering.
- Patients using clinical rooms were cared for in a clean, hygienic environment. All of the clinical areas we visited were clean and well maintained. We inspected toilets and sluices and found them to be clean.
- Clinical waste was removed and bins for sharp items were correctly assembled and labelled.
- The outpatients department had a link nurse for infection prevention and control (IPC) that was responsible IPC in the outpatients department. The departmental link nurse liaised with the trust's IPC specialist nurse.
- The outpatients department were in the process of introducing a decontamination room. Staff told us they had received advice from the hospital's decontamination consultant in developing the room. The room was waiting for couches and ear, nose and throat (ENT) chairs to be delivered. The matron had arranged for staff from Queens Hospital to provide decontamination training for staff at the outpatients department.
- Clean equipment in the room had 'I am clean' stickers to ensure staff knew the equipment was clean and ready for use. 20 staff had received training in decontamination in April 2016. A private equipment provider was also providing regular training for staff in decontamination of scopes.
- We observed cleaning taking place and saw cleaning schedules which were up to date. The matron told us they did 'walk arounds' regularly to monitor cleanliness. The trust's executive team also did regular 'walk arounds' as part of a programme of safety inspections.
- Not all cleaning records for diagnostic imaging department were up to date and we saw that room preparation sheets used in ultrasound had not been completed for several months. This meant we were unable to see documentation that the room cleaning checks had been done.

Environment and equipment

- The audiology room venting system was not working. The room was small and did not have any other means of ventilation such as windows. We saw a patient experience an episode of dizziness and breathlessness in the room. The patient said this was due to a lack of air in the room. The patient was attended by the outpatients' matron and a nurse and recovered quickly. However, staff in the audiology clinic told us they had reported the lack of ventilation to the hospital "some time ago" and they were not aware if the estates department had visited to assess the system.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired.
- Safety testing for equipment was in use across the outpatients and diagnostic imaging departments and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Staff told us the resuscitation lead had reviewed the outpatient department's resuscitation practice in 2015. We found the resuscitation trolleys located throughout

the departments were locked and medicines and stock inside the trollies were appropriate and had been checked daily. Staff reported that these checks were high priority. Defibrillators were tested on a daily basis. Overall, most oxygen cylinders we looked at were in date. The matron in the outpatients department had introduced a daily 'walk around,' where either the matron or senior sister checked records and equipment on all the outpatient resuscitation trolleys. The resuscitation trolley in diagnostic imaging was secure and sealed. Regular checks had been completed and improvements on the process had been made since the last inspection.

- Portable oxygen and suction equipment was available in the outpatients department. We found the equipment was checked daily.
- The hospital were involved in the hospital's 'life study' meetings with the estates department with the intention of moving medical gases off-site. All relevant staff were trained in the safe use and storage of medical gases.
- The 'Base 3' waiting area dealt with orthopaedic patients. Staff told us high back chairs were on order and would be in place by November 2016.
- We observed plenty of specialised personal protective aprons for diagnostic imaging staff and patients to wear as required to give protection from ionising radiation. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- Radiographers did not perform additional Quality Assurance (QA) on a regular basis. The tests were done by medical physics and staff were informed by email. Staff were keen to undertake these tests so that they could monitor the safety of the equipment more closely. Weekly QA tests and daily room set up checks for ultrasound had not been recorded since January 2016
- Clear signage and safety warning lights were in place in the diagnostic imaging departments to warn people about potential radiation exposure.
- Staff told us there was lack of organised storage in the department. One x-ray contained a large ladder leaning against the wall which was a potential hazard to both staff and patients.
- The mammography room was no longer used since the breast screening contract had been awarded to another provider in 2015. The equipment had been left unused for several months with no immediate plans as to what to do next.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the outpatients department. The outpatients' department senior sister did weekly 'walk arounds' these included checks on the contents of medicines cupboards to ensure medicines were in date and no inappropriate items were being stored in the cupboards.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open. Fridge temperature recordings were within the required range.
- Quarterly medicines storage audits were undertaken. The results showed staff followed medicines storage policies appropriately.
- Some nursing staff were nurse prescribers; these were members of staff who had undertaken further training to enable them to prescribe medicines in clinics.
- Prescription pads were stored securely and their appropriate use monitored.
- Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support about medication as part of the patient's consultation.
- Pharmacists had access to GP summaries which meant prescribing errors were less likely.
- We checked the contrast throughout the diagnostic imaging department and all bottles of contrast were found to be in date.

Records

- In the outpatients department patients' records were managed in accordance with the Data Protection Act 1998.
- The trust had changed their electronic system in December 2015 with the introduction of the electronic patient record (EPR), having previously used the patient

administration system (PAS). The EPR provided staff with access to patient letters, reports, imaging and test results. Most patient records were paper based, including risk assessments. Most staff we spoke with commented positively on the EPR.

- The trust had launched 'iFit' a records management system in to address identified issues in regards to missing information in patient records, the over use of temporary records, and the tracking of patient records. Outpatients' department staff had completed workshops on the iFit system.
- Paper based notes were kept in locked keypad trolleys. The outpatients department had introduced a key pad protected notes rooms for each base area, to ensure patients information was protected. Patients attending an outpatient appointment would be booked in at reception. Their notes would be retrieved from the doctors' pigeon hole in the notes room at the time of their appointment and taken to the clinical room.
- However, we found sets of patient notes in an unlocked and unsupervised room which was accessible by the public. This was brought to the attention of the service lead and the room subsequently locked.
- We viewed six patients care records. For example, patients discharge summaries and referral letters were in their care records, together with risk assessments that included a record of patients' allergies, activities of daily living (ADL), whether they were at risk of venous thromboembolism (VTE), and whether they had an assessment of mental capacity.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. Staff said the trust had prioritised staff updating information governance training in the previous 12 months.
- Staff at the eye outpatients department told us there had been improvements in clinical preparation and this had resulted in their being fewer episodes of information being missing from patients' notes.
- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- We saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol.
- Evidence of consent was also observed as completed and appropriate.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to. We reviewed the trust's safeguarding adults' policy. This had a flowchart identifying the trust's safeguarding governance structure. The policy also signposted staff to associated policies and procedures, for example, the trust's 'Prevent' policy and the prevention and management of violence against staff policy.
- The outpatients department had a link nurse for safeguarding. The staff we spoke with was aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Most staff were able to describe different types of abuse. However, the phlebotomy clinic staff told us there was no safeguarding link staff for phlebotomy.
- The outpatients department senior sisters office had the contact details of the local authority safeguarding team and domestic violence unit displayed on the office notice board to enable staff in having easy access to contact information.
- Bank staff received the same safeguarding training as permanent staff and ad hoc training was also provided by safeguarding team as and when required.
- We saw evidence that the staff were 100% compliant with level 1 training and 92.8% for level 2 adult training and 91.5% compliant for level 2 child training.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time.
- The outpatient department mandatory training spreadsheet for September 2016 recorded that most staff training was up to date. Mandatory training included: fire safety, health and safety, moving and handling, paediatric and adults resuscitation.
- Mandatory training was available via on-line courses as well as face to face.

Outpatients and diagnostic imaging

- Radiology management told us that all radiographers were up to date with their mandatory training and all staff we spoke to confirmed this.
- Figures showed compliance of 91.3% for mandatory training as a whole against a trust target of 90%. Radiology staff exceeded the trust target in all subjects with the exception of basic resuscitation.
- Training for staff in basic life support was mandatory in the outpatients department, this included staff working on the departments' reception desk.

Assessing and responding to patient risk

- There were arrangements in place to deal with foreseeable medical emergencies. Senior managers told us that escalation of risk was normally done from a ward level. Ward managers discussed risk with their line managers who escalated to the service director, then onto the risk register if required.
- Referrals were immediately logged onto the EPR, which identified patients who were at risk of deteriorating.
- If a patient became unwell in outpatients, the service had a clear protocol to follow. Staff would assess the patient using the National Early Warning Score (NEWS) and either treat the patient within the department or, if the department could not meet their clinical need, transfer the patient to the emergency department for a full assessment and treatment.
- KGH was supported by an 'in-house' radiation protection service. They provided the radiation protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for lasers and magnet use within diagnostics throughout the trust.
- There were radiation protection supervisors (RPS) allocated to the department. One RPS told us they had not had training for several years and did not fulfil the duties of an RPS due to other demands on their time. There was no evidence of training records for the RPS role on the shared drive.
- Dose reference levels had been established for the X-ray rooms. Automatic exposure factors were used in all x-ray rooms viewed. This is acceptable practice as long as the exposure parameters have been optimised.
- They were no local rules visible on the mobile imaging equipment or in the x-ray rooms. These were located on the shared computer drive but were difficult to locate. It took several attempts to locate the correct file.
- The risk assessments in ultrasound had expired in June 2015 and were currently not up to date.
- There was one risk on the trust wide risk register relating to a backlog of plain film reporting from 2012/2013. We were assured, following discussions with radiology management that work had been done to address this matter to reduce the risk to patients. In 2012 there was a backlog of 15,384 reports to be done. The latest figures in April 2016 demonstrated only six reports were outstanding.
- Radiography staff within the reporting team told us there was no current backlog with their workload. All urgent reporting was done in less than 30 minutes but there was no data to confirm this.

Nursing, radiology and administration staffing

- Nursing services in the outpatients department were provided by the outpatient nurses and clinical nurse specialists (CNS).
- Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. A safe staffing dashboard was displayed in the outpatients department. This showed details of the required levels of staffing, and actual levels present on each day. Staffing levels were adequate, as was the required skill mix at the time of our visit. The matron demonstrated an online acuity tool which was used to assess the required staffing levels for each day.
- There was a bank for nursing staff so the hospital had cover for staff sickness and holidays. Bank staff had an induction and mandatory training was provided. Many of the bank staff had worked at the hospital before and were familiar with the trust's processes.
- The radiography staffing vacancies had now been filled with the exception of ultrasonographers. Agency staff covered the gaps in the rota to offer the musculoskeletal service. Any agency radiography staff were given a thorough induction programme.
- We spoke to a new member of staff who had completed a trust and departmental induction..

Outpatients and diagnostic imaging

Medical staffing

- Clinical staffing in all outpatient and imaging departments was good. However, staff at the urology clinic told us there was an unfilled consultant post and this had led to staff struggling with clinics.
- Staff at the neurology clinic told us they had received trust funding for three new registrar posts and two new rheumatologists.

Major incident awareness and training

- Staff in the outpatients department were aware of the trust's business continuity policy; senior staff understood their roles and responsibilities within a major incident. Staff told us there were staff allocated to assist in the event of a major incident.
- The outpatients department had a contingency plan in place for junior doctors' strikes. This included: letters being sent first class to all patients with appointments affected by the strike, updating staff at the call centre of clinics affected by strike action. Reception staff being provided with a list of patients affected by strike action as well as patients attending clinics.
- The service manager told us the hospital followed up every junior doctor's strike with a lessons learned session in the team meeting as part of the hospital's contingency planning.
- We noted there was a major incident procedure for imaging, which was also part of the wider hospital major incident policy.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The outpatients and diagnostic and imaging service were inspected but not rated for effective. We found:

- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based.
- Early work was in progress for imaging to gain accreditation with the Imaging Services Accreditation Scheme (ISAS).
- Imaging local rules for the hospital had not been updated since 2014.
- Staff were able access appropriate pain relief for patients.
- The service was monitoring the care and treatment outcomes of patients who were receiving outsourced care from providers in the private sector.
- All new staff completed a corporate and local induction.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available in a wide range of specialities. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.
- Staff were competent to perform their roles and took part in benchmarking and accreditation schemes. Staff were supported in their roles by on-going specialist training and development opportunities.
- The outpatients department and diagnostic and imaging services had introduced clinics Monday to Sunday to clear patient waiting list backlogs.

Evidence-based care and treatment

- There was a comprehensive set of treatment guidelines based on guidance from the National Institute for Health and Care Excellence (NICE). Doctors in the outpatients department were able to show us that they were complying with best practice guidance. Diagnostic services were delivered in accordance with Department of Health and Royal College of Radiologists guidance.
- Staff were familiar with their use and they were easily available on the trust's intranet. Any changes were discussed at governance meetings and updated as necessary. Staff told us changes to policies or procedures would be discussed at daily huddle meetings and team meetings.
- We viewed a selection of trust policies including the chaperone policy. The chaperone policy had been reviewed and ratified in October 2015 and was next due for review in November 2016.
- We found staff in the phlebotomy clinic followed national guidelines and had standard operating procedures (SOPS). Staff received instant updates via email if there were changes in guidance or SOPS.

Outpatients and diagnostic imaging

- The pathology department had full Clinical Pathology Accreditation (CPA) and was in the process of moving to an internationally renowned quality standard for medical laboratories (ISO 15189)
- The blood transfusion service was fully compliant with the Medicines and Healthcare products Regulatory Agency (MHRA)
- The trust had established a combination of local and national diagnostic reference levels (DRLs) within radiology. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses however, they can be used as a signpost to indicate to staff when equipment is not operating correctly. More work needed to be done to complete the DRLs on the KGH site.
- The RPA told us they would be introducing new European protocols to enable the department to become accredited with the Imaging Services Accreditation Scheme (ISAS).
- Imaging protocols for radiology were regularly reviewed and involved the input of the wider team.
- All radiology reports were done in-house and none were outsourced. Radiology reporting times were now being monitored on a departmental dashboard since June 2016.

Pain relief

- Staff were able access appropriate pain relief for patients within outpatient department clinics.
- Staff told us they could bleep the pain management team who would attend to a patient experiencing pain.
- Records confirmed that patients' pain needs were assessed before undertaking any tests in the majority of cases.
- Staff at the pain clinic told us they had received approval to expand the service and were in the process of interviewing a psychologist and a further pain nurse.

Patient outcomes

- The trust had introduced a performance pack as a result of a 'deep dive'. The deputy chief operating officer (COO) said the data from the analysis had been used to demonstrate to clinicians how the changes in the outpatient department's working processes had been measurably beneficial for patients.
- The hospital were using a range of private providers to assist in clearing the backlog of both admitted and non-admitted patients where there was the most demand on the service. The deputy chief operating officer (COO) told us the hospital looked daily at patients referred to a private provider and tracked and monitored their care and treatment. The COO showed us documents that evidenced how the hospital met with providers weekly and identified where patients were on their care and treatment journey. For example, the 1 September 2016 performance report recorded that outsourcing had resulted in an average of 98 patients receiving outsourced care and treatment a month since April 2016.
- All of the patients we spoke with attending for an imaging appointment were positive about attending the service.
- An IR(ME)R audit was last done in 2014. We looked at the action plan and saw that KGH was not compliant with the audit. We did not see an updated action plan. The RPA told us the IR(ME)R procedures were being updated but these still currently showed a review date of 2012 on the electronic system.
- Radiology management told us they Did Not Attend (DNA) rates were low within the service. A new centralised radiology booking system had been out in place over the last few months. We spoke with the project team and it was evident the change process to the new system was being closely monitored and improvements made

Competent staff

- Staff received regular supervision and team meetings within outpatients. Team meetings had recently been put in place for diagnostic imaging.
- 52% of radiology staff had completed an appraisal. This was recorded as a rolling figure. Department leads told us all staff would complete their appraisals within the

correct timeframe. However, the mandatory training spreadsheet for the outpatients department, September 2016, recorded that 27% of staff had an up to date appraisal, this was below the hospital's target of 85%.

- Data provided by the hospital recorded that on the 16 August 2016, across the cancer division, 76.6% of staff had received an annual appraisal. This was below the hospital's target of 90%.
- Competency assessments were in place for outpatients and diagnostic imaging and induction processes were in place for new staff. All new staff completed a corporate and local induction. Senior staff in diagnostic imaging told us the local induction pack was being revised. Induction checklist were recorded on outpatient staff electronic training records.
- We spoke with health care assistants (HCA) and observed the care they were giving in clinical areas. Some HCA's were trained for specific tasks, for example taking blood or taking physiological measurements. HCA's told us they received direct supervision from registered nurses. HCA's told us their electronic training records recorded any specialist training they had undertaken and they received emails to notify them when training updates were due.
- Staff were able to obtain further relevant qualifications. Staff said there was a range of in-house training opportunities.
- Staff were supported with revalidation of their registration with their professional regulatory bodies.
- Health care assistants had 'development days' where staff could look at practice issues and learning from practice.
- The outpatient department had a range of link nurses
- Completion of mandatory training was a high priority for all staff and managers we spoke to.
- We saw evidence of role development for radiographers which included film reporting in plain film, breast and chest x-rays. The radiographer led reporting service was effective in keeping reporting turnaround times within target levels.
- Some radiography staff were trained in cannulation and their competency checked before starting this advanced skill.
- Radiographers told us that new departmental clinical leadership was supportive of radiographer role progression.
- We saw that all employed radiography staff were registered with the Health Care Professions Council (HCPC).Managers checked the registration of their staff regularly.

Multidisciplinary working

- Outpatients department nursing staff told us there was increased cross site working with the outpatients department at Queens Hospital with outpatients nursing staff from both hospitals offering additional cover. However, staff also highlighted that different clinics at both sites limited the number of nursing staff that could cross site work. Some of the diagnostic imaging staff worked across both sites but this was quite limited.
- The outpatients' department matron managed both the outpatients department at Queens Hospital and King George's Hospital and diagnostic imaging had a general manager across both sites.
- There were no formal meetings between phlebotomy clinic staff at King George's Hospital and Queens Hospital. However staff rotated between both sites, including managers. Cross site working was on a basis of planned and emergency planning.
- There were regular multidisciplinary team (MDT) meetings in the outpatients department which were well attended by other healthcare team members, including radiology.
- The outpatients department had link nurses for safeguarding, learning disability, wound management and palliative care.
- Therapists including OT and physiotherapists were part of the outpatients department MDT.
- Staff in the outpatients department told us they collaborated closely with doctors and physiotherapists.
- Staff at the audiology service told us they had "little interaction" with staff at the outpatients department.
- Patient information was shared with GP's following outpatients' department attendance to ensure continuity of care.

Outpatients and diagnostic imaging

- The hospital worked closely with a range of external providers as an aspect of their demand and capacity management. We viewed the trust's demand management report dated 1 September 2016, this contained updates in regards to redirected appointments. As at the week ending 28 August 2016 the trust had redirected 6,747 patients via planned schemes with external providers.

Seven-day services

- Outpatients' clinics operated from 9.00am to 5.00pm Monday to Friday. However, the department had introduced clinics until 10.30pm from Monday to Sunday. As a result there were regular weekend clinic appointments in the outpatients department. Weekend clinics had been introduced to reduce the outpatients' department waiting lists and patients' referral to treatment times (RTT).
- Diagnostic imaging provided a 24-hour, seven day service with a combination of extended days and on-call cover.
- CT and MRI ran extended days during the week and at the weekend.

Access to information

- Staff across all the departments we visited demonstrated how they could access the information needed to deliver effective care and treatment in a timely way from the EPR. Staff showed us how they used the EPR to gain access patients test results.
- Diagnostic results were recorded on patient EPR's, giving staff across the trust immediate and up to date access to patients' records.
- The outpatients department had a preparation room. Staff received up dated patients' clinical information in the preparation room in readiness for clinics. Paper records we saw were up to date and written clearly.
- The outpatients department had introduced a clinic co-ordinator who took all calls and messages to the service and disseminated information to staff. There was a rota that identified nursing staff that were covering the role. Staff said the introduction of a co-ordinator had improved communication in the department.
- Staff in the audiology clinic told us the computer they used for bookings had broken down six weeks ago. This meant they were taking all bookings as paper copies.
- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records were stored securely and access was password protected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw nursing staff in the outpatients department seeking consent before carrying out tasks. Verbal consent was observed in the X-ray room. Staff we spoke with understood the need for consent and ensuring this was recorded appropriately.
- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. Most of the patients we spoke with told us the staff had explained the proposed treatment or test and had confirmed with them that they had consented before any examination or treatment had taken place.
- If written consent was required for more complex procedures this was obtained in outpatients clinics by medical staff.
- Clinical nurse specialists were able to describe the process of assessing capacity when obtaining consent.
- The safeguarding team delivered training on mental capacity, deprivation of liberty safeguards (DoLS), and prevent. There was also information available to staff on the trust intranet.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a good knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).Staff in diagnostic imaging reported they had received update training at a recent staff meeting.
- Staff knew the procedures to follow to gain consent and understanding from patients, including involving other professionals. Carers were encouraged to escort their relative to appointments where needed to offer support.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

We rated caring good because:

- All the patients, relatives and carers we spoke with were positive about the way staff treated people. There was a strong, visible person-centred culture in most departments. Staff offered care that was kind and promoted people's dignity. We observed staff being caring and supportive in interactions with patients and their families.
- Patients and relatives told us they were involved in decision making about their care and treatment. People's individual preferences and needs were reflected in how care was delivered.
- Staff demonstrated awareness of people's needs and the limitations associated with their conditions. Patients' psychological and emotional needs were appropriately supported.

Compassionate care

- Most patients in the outpatients department spoke positively about the staff that supported them with their care and treatment and considered them knowledgeable and professional. We did not receive any negative comments from patients, their relatives or carers about staff attitudes or behaviour towards them in the outpatients department. A typical comment was, "The staff are friendly, they always talk nicely to me, I feel respected." Another patient told us, "The doctors are very caring and ask me how I am feeling and if I have any pain." However, another patient told us, "The staff at the weekend seem stressed."
- We saw the matron and outpatients nurse attending to a patient who had become faint in the audiology room. Overall, the outpatients department respected patients' privacy and dignity. The department had moved the clinical observations area from a public waiting area to the assessment room. This ensured patient privacy when undergoing tests such as blood pressure and weight.
- We observed chaperones working in the ultrasound department.
- Staff we spoke with were very proud of the care and support they provided to patients and their families. Receptionists were welcoming and friendly. We saw porters and housekeeping staff interacting with patients in a caring manner.

Understanding and involvement of patients and those close to them

- Overall, patients and relatives told us they were involved in decisions about their care and treatment. For example, one patient told us, "They explained my treatment to me."
- Managers and staff told us actions were being taken to address patients missing appointments, including sending texts to patients' mobile phones, where patients were in agreement to receive them.
- A patient in the outpatient department told us, "The doctor is very nice, they ask me to come in a week early for bloods, so that they have the results ready for today. The doctor has been wonderful."
- The outpatients department had a patient visual display unit call system that informed patients when it was their turn in clinic.
- Patients told us they received instructions with their appointment letters and were given written information as required. We observed staff in the diagnostic imaging department escorting patients and their families to the correct waiting are for their examination and explaining what was to happen next to them
- The outpatients department took part in the 'iWantGreatCare' patient experience survey. Departments we visited had boxes where patients could leave comments or suggestions using the forms provided.
- There was a range of printed information available to patients and their families and carers, including a range of information leaflets and literature for patients to read about a variety of conditions and support services.
- The services had a chaperone policy in place to protect patients and staff.

Emotional support

Outpatients and diagnostic imaging

- Staff told us King Georges Hospital multi-faith chaplaincy could provide listening and emotional support if requested to all patients.
- The hospitals psychological service provided psychological and psychiatric consultation, assessment and therapeutic intervention to patients and their families and carers.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive requires improvement because:

- Staff told us they were not confident of meeting the national indicator for patients waiting over 18 weeks by their target date of March 2017.
- The percentage of patients who did not attend (DNA) their appointment was above the England average.
- The trust's performance for the 62 day cancer waiting time was consistently below the 85% England average from 1 March 2015 to 31 May 2016.
- 13% of appointments were cancelled by the hospital. This was higher than the England average of 7.2%.

However, we also found:

- Work was in progress to conduct a demand and capacity analysis in partnership with a private company that specialised in risk and trend analysis to develop a model whereby the hospital could assess and effectively manage the demands on the service.
- There had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016.
- The hospital was using a range of private providers to assist in clearing the backlog of appointments where there were most demand for services.
- There was a formal complaints process for people to use with investigation, and response to the complainant. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms.
- Breast screening services had been discontinued in the trust but patients were able to access a mobile van within the car park of the hospital.

Service planning and delivery to meet the needs of local people

- The deputy chief operating officer (COO) had joined the hospital in April 2016 and had conducted an analysis of patients that had waited for an appointment for over 52 weeks. As a result the hospital identified that a further 6000 appointments were required to provide these patients with care and treatment. An action plan and timescales were in place as a result of the analysis.
- Work was in progress with the outpatients department to conduct a demand and capacity analysis in partnership with a private company that specialised in risk and trend analysis to develop a model whereby the hospital could assess and effectively manage the demands on the outpatients department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.
- Managers told us there were a variety of models for the outpatients department. This included a traditional outpatients model, nurse led clinics and rapid access services. For example, the King George's Hospital offered a rapid access prostate clinic as well as a 'one stop' haematuria, (blood in the urine), clinic.
- Outpatient department appointments offered a mixture of nurse and medical led clinics. General outpatient nursing services included a variety of tasks and tests, which included: dressings; injections; phlebotomy, blood tests; urine tests; body mass index (BMI) measurements, blood pressure measurements; and administration of medicines.
- There were plans for the outpatients department to move into the area occupied by a G.P service next to the outpatients department. This would provide a new reception area and an increased phlebotomy area.
- The medical director told us the trust were holding joint meetings with primary care providers, for example GPs, to look at patient pathways and how GPs assessed and referred patients for appointments. As a result the trust were changing GP referral templates which would provide GP and hospital staff with more information.

Outpatients and diagnostic imaging

- Minor operations were completed in clinical rooms, with the exception of dermatology which would be referred to Queens Hospital outpatients department.
- The second MRI van was now leased by the trust and not outsourced to an external provider.
- The removal of the breast screening service meant that the equipment and room were not in use.

Access and flow

- The trust's outpatients and diagnostic imaging departments offered 817,013 appointments between 1 March 2015 and 1 March 2016. 542,590 were first or follow up appointments.
- At King George's Hospital 22% were new referrals. This was below the England average of 24.8%. Most appointments were follow-up appointments and accounted for 43% of all the appointments provided. This was below the England average of 54.5%. The overall follow up to new rate for the trust was in the lowest quartile of hospital trusts. However, from March 2015 to February 2016 the follow up to new rates for King George's Hospital were similar to the England average.
- The percentage of patients who did not attend (DNA) their appointment was 10%; this was above the England average of 6.8%. Managers said they recognised that the DNA rate was too high. The hospital had introduced an initiative whereby patients would not be discharged following their first missed appointment; they would instead be given three weeks' notice.
- An average of over 600 bloods were taken daily by the phlebotomy service.
- Staff at the outpatients administration team told us there had been a problem with patients not receiving reminders due to a system failure. This had been identified and rectified, but staff thought this had been a contributory factor with the DNA rate.
- The trust's performance for the 62 day cancer waiting time was consistently below the 85% England average from 1 March 2015 to 31 May 2016.
- The outpatients department service manager told us the 'demand and capacity analysis' had identified all patients that had exceeded a 52 week wait. In response the hospital had introduced a patient tracking list (PTL) where the data was validated by a private company. However, the hospital's information management and technology team (IMT) was in the process of taking the data validation in-house. The IMT team would be responsible for collating the referral to treatment (RTT) PTL.
- No RTT non-admitted or incomplete pathways data was publically available. Mangers told us the hospital were not reporting or publishing their RTT due to the 52 week wait. Staff told us the hospital wished to ensure the RTT PTL as the hospital wished to ensure the validation system was robust. Senior managers told us the hospital was on-track to clear the backlog of patients waiting over 52 weeks for an appointment by the end of September 2016.
- The RTT performance pack dated 1 September 2016 recorded there had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016.The trust had analysed the trajectory for these patients and were 387 appointments ahead of the planned target.
- Staff told us they were not confident of meeting the national indicator for patients waiting over 18 weeks by their target date of March 2017.
- The percentage of people with an urgent cancer GP referral seen by specialist within two weeks had fallen below the England average in quarter four, October to December 2015.
- The percentage of patients (all cancers) waiting less than 31 days from urgent GP to first definitive treatment was around the 95% standard.
- Between November 2015 and March 2016 the trust had a high proportion of people waiting over six weeks for diagnostic tests when compared to the England average. However, the trend was from a peak in January 2016 to below the England average in April and May 2016. The trust reported that over 99% of patients were now seen within six weeks.
- 13% of appointments were cancelled by the hospital. This was higher than the England average of 7.2%. 11% of appointments were cancelled by patients. This was also higher than the England average of 6.6%.
- The trust's medical director told us the trust had an established harm, panels which had reviewed the

admitted patients' pathway to assess degrees of patient harm. Three minor harms had been identified as a result of the review. The trust had also sampled 10% of non-admitted patients and identified no harm to patients with the longest waits. The assistant medical director had continued to review patients via 'dip checks.'

- The medical director told us the challenge for the trust in regards to RTT was patients waiting 18 to 52 weeks. The medical director said there had been a number of discussions with the COO with regard to patient safety whilst patients waited for an appointment. The medical director highlighted that the numbers of patients waiting for appointments was reducing. The hospital had introduced initiatives to reduce patients RTT, including reviewing patients arriving in the emergency department (ED) to establish if the presenting problem was related to an outpatient's department appointment.
- We viewed the ophthalmology overarching action plan update dated 5 September 2016. The action plan was regularly reviewed. On-going actions included all patients receiving their follow up appointments prior to leaving the clinic and the provision of timely follow up appointments, which had a target date for completion of 30 September 2016.
- Staff told us clinics were sometimes delayed by patients having more complex conditions that required extra time. Staff said they would speak with patients that had appointment times delayed, and that they always announced delays in clinic schedules in the waiting room as well as delay notices being broadcast in the waiting room.
- Staff at the rheumatology clinic said managers were monitoring potential RTT breaches and they would receive an email prompt from managers when there was a potential RTT breach for a patient. This was echoed by staff from the neurology clinic who told us how to reduce patients RTT was discussed at team meetings and junior doctors were offered training in completion of RTT forms. Staff at the outpatients administration team monitored patients from first appointment and also confirmed that RTT waiting times were monitored by the COO.
- GP's could use the outpatients' department 'choose and book' online appointments system, e-referrals, or paper based referrals. Consultants triaged referrals and secretaries booked appointments. Staff told us patients could rearrange appointments if the allocated time wasn't convenient, once they had received an appointment letter.
- Staff said same day appointments could be arranged for urgent referrals as departments scheduled urgent appointments daily.
- The outpatients department had introduced 'quality of care' tracking lists for patients to monitor individual patients' access to assessment, diagnosis and treatment. The patients waiting time and time of their appointment were being monitored as an aspect of the trust's demand and capacity review.
- The trust had a call centre based in King George's Hospital. The call centre handled approximately 6000 calls a week. The answer rate for the call centre was 95% and the time to answer calls was an average of 46 seconds. The outpatient clinics were in the process of reviewing their directory of services (DOS). These are pathways that provide the call handler with real time information about services available to support a particular patient and ensure they are directed to the appropriate service.
- Patients could receive text reminders for outpatients' appointments. However, staff told us patients had to 'opt in' to the text reminder service due to data protection, as the service was provided by a private company. A few patients we spoke with in the outpatients department and phlebotomy clinic told us they had received their text reminder before they had received an appointment letter. Staff told us this was possible due to letters being prepared manually. Staff added that this was being addressed as the trust was outsourcing their electronic mailing system from October 2016 to a private provider with the aim of speeding up outgoing mail processes.
- The hospital had introduced a 'quick triage' service for patients with non-complex needs. This involved patients having blood tests, initial assessment, height and

weight measured, and MRSA screening. Staff told us the 'quick triage' had been introduced as the outpatients department had recognised the need to be creative in speeding up patients' access to care and treatment.

- The referral to treatment time (RTT) for the audiology clinic was four to six weeks. Staff told us follow up appointments had a 10 week waiting time.
- The outpatients department had installed large screens that carried messages for patients, including the current waiting time. The waiting time on display at the time of our visit was 45 minutes. We saw that on the day we visited most people were seen within the 45 minute waiting time.
- If clinic appointments in outpatients were delayed staff told us they would inform patients verbally of waiting times. The large screen also informed patients of different consultants who were working to enable patients to understand why some patients appeared to be going into their appointment before them.
- Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge.
- We asked patients about attendance at appointments. Some patients told us they had cancelled their appointments due to personal circumstances but had been dealt with politely and always offered an alternative.

Meeting people's individual needs

- The outpatients department had access to a range of support to meet patients' individual needs including: physiotherapy.
- The outpatient department had introduced new reception desks with a dip in the desk, these made face to face interactions with reception staff accessible to wheelchair users. Separate waiting areas in the outpatients department had 'pods' to check patients into clinics on arrival.
- Staff we spoke with told us there was a lot of focus in the outpatients department on how services could meet the needs of patients with a learning disability or patients with dementia. For example, the outpatients department had a phlebotomy clinic for patients with learning disabilities. The diagnostic imaging department staff were less able to communicate clearly how they made adaptations for specific patient needs.
- Staff at the outpatients department told us they supported people with learning disabilities regularly. Staff said letters could be provided in 'easy read' formats or large print. Staff said if they were aware of a vulnerable adult attending an appointment they would provide assistance.
- There were learning disability notice boards and notices in the outpatients department's waiting area in easy read format explaining how people with a learning disability could access assistance in the department.
- The outpatients department used the hospital passport scheme for patients with learning disabilities. This was a document patients could take to their appointments which carried information about the patients personal, communication, and health care needs.
- Arrangements for patients with complex needs were discussed at morning 'huddle' meetings. This included patients with learning disabilities or mental health issues being provided with a room where they could wait away from other patients where this would be beneficial.
- There was provision for bariatric patients in the form of bariatric treatment table in the treatment room. Staff in diagnostic imaging were able to tell us the weight limits for the CT table and how they would undertake a risk assessment prior to proceeding with an examination if there were any concerns.
- Staff told us the trust's accessible communications team could provide printed information in a range of languages upon request.
- Interpreters offering both face to face and telephone interpreting could be pre-booked for patients that didn't speak English. Staff told us some members of staff also spoke other languages and could be approached to act as an interpreter.
- The outpatients department had replaced the furniture in the outpatients department waiting areas in the

previous 12 months. The department had also introduced television screens that showed news programmes with subtitles and visual display units for clinics.

- The number of seats in the phlebotomy clinic had been increased. On the day we visited there was ample seating for the number of patients using the clinic. Staff told us there were still waiting issues in the phlebotomy clinic on Monday and Tuesday, but patients would be offered seating in the "base three waiting area, but they can't see the appointment screen from there." However, plans were in place to develop the phlebotomy area in December 2016. Staff added that if the phlebotomy clinic was "very busy" they had the option of sending patients to Loxford.
- The neurology clinic was provided by the hospital's day care unit. However, the outpatients department had neurology 'hot clinics', these were clinics running in the evening and at weekends.
- The outpatients department would remain open for patients that were being admitted and waiting for a bed where a bed had been identified. If a bed had not been identified and patients wait was likely to be late in the evening, staff said they would transfer the patient to the hospital's emergency department until a bed was ready. A senior sister said, "Staff are really supportive of staying late with patients waiting for admissions."
- The outpatients department had a publishing company that provided free magazines for the waiting area for patients to read whilst waiting for their appointments. The company updated the magazines monthly.
- The outpatients department had introduced children's play areas in adult waiting rooms for patients attending appointments with children.
- Patients attending the outpatients department had access to a coffee shop in the hospital's main reception for snacks and tea and coffee.The outpatients department had introduced water dispensers in the waiting rooms to ensure patients their carers and families had access to free drinking water.
- The outpatients department had recently opened a children's waiting room in the outpatients department. This had child friendly décor and a small range of children's toys and books.
- The hospital had a multi-faith prayer room that was open 24 hours a day. Staff told us people of all faiths could use the room and all were welcome to the regular services. These were Christian prayer on Wednesdays from 12 noon to 12.30pm, and Muslim Jummah prayers on Friday from 1.00pm until 2.00pm.

Learning from complaints and concerns

- Staff told us they spoke with patients regularly to prevent any concerns that patients or families had from escalating. There was a formal complaints process for people to use with investigation, and response to the complainant. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms. Staff told us most complaints related to waiting in the waiting room and waiting times for appointments.
- Most patients we spoke with told us that they knew how to make a complaint and would feel comfortable making a complaint. A patient told us, "I would ask to speak to the manager if I had a complaint, but I haven't had anything to complain about."
- The outpatients' department general information board displayed the complaints procedure.
- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the departments we visited.
- Staff had access to an easy read complaints policy for people who required information in this format.
- Staff in both the outpatients and diagnostic imaging department told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If it could not be resolved by the team, staff told us people would be given the contact details of the patient advice and liaison service (PALS).
- The deputy COO told us the external clinical harm review panel reviewed complaints monthly. The panels were also attended by representatives from the CCG and PALS.
- The medical director told us the hospital had reviewed 247 complaints via PALS. Eight of these were related to patients' referral to treatment time (RTT).

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Staff knew and understood the vision of the trust. We found that most local managers demonstrated good leadership within the department and the division.
- Managers had knowledge of performance in their areas of responsibility and understood the risks and challenges to the service.
- Managers and clinical leads were visible and approachable.
- There was a system of governance and risk management meetings at both departmental and divisional levels.
- Patients' and staff views were actively sought and there was evidence of continuous improvement and development of staff and services.

However, we also found:

- Outpatients and diagnostic imaging services were in transition, and the strategy for these services was in development.
- There were a number of new senior manager that had introduced new quality assurance and risk measurement systems. However, these were not fully embedded.
- Diagnostic imaging services were working at full capacity in some modalities. We did not see a clear strategy to deal with the increasing demand.

Leadership of service

- Senior managers we spoke with had knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service. Most senior and middle managers we spoke with told us the executive team were supportive. Most managers told us they had confidence in the CEO and the board.
- The COO had overall responsibility to co-ordinate outpatients services and two deputy COO's had been recruited. Most staff in the outpatients department told us the divisional lead for the cancer division and the service manager were approachable. The matron in the outpatients department had worked for the trust for 11 years. Staff told us locally outpatient department managers were more visible in the department.
- The trust had introduced a divisional leaders programme to provide divisional leads with divisional management skills and knowledge.
- Senior managers told us the managerial skills and knowledge of local managers was "a bit mixed." Senior managers told us, "overall managers and staff have embraced changed; most staff have come on board."
- Monthly outpatients' and diagnostic imaging team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust. Most staff we spoke with felt supported and valued in their role.
- There was a CEO forum which some staff told us they had attended and reported back to their teams. This facilitated an effective channel of communication between the board and staff.
- The staff we spoke with in diagnostic imaging were overall happy with the new leadership and felt less stressed than the previous inspection. They now felt listened too and were hopeful the department would move forward.

Vision and strategy for this service

- Managers told us the outpatients and diagnostic imaging services were in transition, and the strategy was in development. The strategy would be based on the 'demand and capacity' model the hospital was developing with a private provider of risk and trend analysis. We were told the model would streamline scheduling and reduce waits, as well as determining the staffing needs of the service in response to service demand.
- The outpatients department had a mission statement and philosophy of care. This was displayed in the sisters' office. The diagnostic imaging department had relatively new leadership. They expressed a desire to keep moving in the right direction after internal special measures lifted from the service.

Outpatients and diagnostic imaging

- All of the staff we spoke with were aware the trust had introduced an improvement agenda and the trust's vision and values were related to this. The trust values were based on the acronym, 'PRIDE', which stood for 'passion, responsibility, innovation, drive, and empowerment.' Staff were expected to demonstrate the core values of the trust.
- Several staff in diagnostic imaging told us they felt the department was now more stable under new leadership.

Governance, risk management and quality measurement

- The outpatients department were part of the cancer division, with the divisional lead feeding back to the board.
- The hospital were introducing a range of governance processes, but these were relatively recent and not fully embedded. The hospital had introduced a 'performance pack' suite of reports that provided information on RTT performance. The deputy COO told us the reports provided the hospital with "clear visibility and accountability" with the aim of reducing the number of patients waiting for over 52 weeks for their care and treatment. Information from the suite of reports was included in outpatients' teams' daily reports.
- We viewed the performance pack 1 September 2016. The pack demonstrated that the hospitals RTT had consistently reduced between May 2016 and August 2016. For example, the total incomplete PTL had reduced in the period by 867 but was still 47,574. The incomplete patients waiting from 18 to 51 weeks had reduced by 200, but still stood at 13,634, but this was a significant reduction from the May 2016 figure of 18,157. The incomplete patients over 52 week had reduced in the May 2016 to August 2016 by 41, but 317 patients were still waiting over 52 weeks.
- The medical director told us the board were pragmatic and recognised that due to the size of the waiting lists it would take time to meet the national waiting list indicator. The medical director said there had been significant reductions in RTT PTL and also recognised the efforts of staff at all levels in reducing these.
- The CCG attended the hospital's performance management office (PMO) RTT programme board weekly with the trust's executives.
- The performance pack was regularly reviewed at weekly meetings. These included the PMO operational meeting and the access board meeting.
- There were monthly head of division and head of service meetings. Learning from divisional and service level meetings was disseminated to team leads, who disseminated learning from divisional meetings at team meetings.
- The hospital had introduced a programme of supportive measures as part of the hospital's improvement programme. Clinics in supportive measures included gastroenterology and neurology.
- New governance procedures had been introduced in the diagnostic imaging department. A performance scorecard measured departmental performance across both Queens Hospital and KGH. We reviewed the scorecard which demonstrated results against key target areas. More work was needed to fully complete the scorecard with the required data.
- The action plan for the haematology and immunology department in place in 2014 was now completed. Senior staff told us they had recently joined the cytology and histopathology departments to form a cellular pathology department. Cross site training of staff took place to improve processes and efficiency across the service.

Culture within the service

- Managers we spoke with told us staff had engaged with the 'performance pack' and reports initiative. However, a few staff we spoke with told us they felt that managers had imposed the pack on them; but, other staff were positive about their introduction. A typical comment was, "the staff have worked really hard to make changes happen."
- Most staff we spoke with reported that morale was good and had improved across outpatients and diagnostic imaging. Most were positive about services and felt positive about their role and contribution to this. However, a few staff told us they did not feel fully consulted on how they felt and what they would like to change.

Outpatients and diagnostic imaging

- We observed radiography staff able to take breaks in a newly renovated courtyard in the centre of the department. Staff told us this was a welcome addition and made good use of the space. Senior leadership told us it was now time to value the staff and retain and develop talent.
- The chief executive officer had an open door policy allowing staff to make their thoughts and opinions known. There were mechanisms in place for whistleblowing.
- Staff told us a culture of reporting incidents and concerns was encouraged. The electronic incident reporting system prompted staff to record whether Duty of Candour (DoC) requirements had been fulfilled.

Public engagement

- People with learning disabilities had advised the outpatients department on making the department more learning disability friendly. We saw 'it's good to talk' patient information boards in the outpatients department that carried posters and information for people with learning disabilities.
- We saw a group of volunteers providing information on hospital volunteering and support groups in the hospital corridor.
- The outpatients department had introduced 'you said, we did' boards. For example, the board acknowledged that the department needed to get better at "reducing waiting times."
- The matron had introduced 'meet the matron' days, these were days when the matron ran a stall in the outpatients department providing both verbal and written information on staff roles, different outpatients department specialities and clinics, as well as answering any questions patients, families and carers might have.

Staff engagement

- Staff were invited to add to the matron's outpatient department improvement plans at monthly staff meetings. Staff were also updated on the hospital's improvement plans at the meetings.
- Staff had access to independent and confidential counselling and support services via the hospital's occupational health department.
- Several staff told us they felt proud to work for the trust, they felt more improvements could be made regards to change and how the process was communicated.

Innovation, improvement and sustainability

- Most of the staff we spoke with reported improvements at the hospital. The outpatient's manager conceded that waiting lists were still long, but highlighted the improvements the hospital had made over the previous 12 months in reducing these. Staff in diagnostic imaging were able to show improvements in waiting times and reporting times. The radiography staff in the reporting service were to be commended for their 'can-do' attitude and professionalism in driving the service forward.
- The hospital had introduced the 'performance pack' to give aid managers and staff in managing the outpatients' department demand and capacity and reduce waiting lists.
- The hospital had introduced a 'quick triage' service for patients attending outpatient clinics with non-complex needs. This involved patients having blood tests, initial assessment, height and weight measured, and MRSA screening.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to make their stay in hospital easier and reduce any emotional distress.

Areas for improvement

Action the hospital MUST take to improve

- Ensure all patients attending the ED are seen more quickly by a clinician.
- Take action to improve levels of resuscitation training.
- Ensure there is oversight of all training done by locums.
- Take action to improve the response to patients with suspected sepsis.
- Take action to address the poor levels of hand hygiene compliance in ED.

Action the hospital SHOULD take to improve

Emergency Department

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Increase paediatric nursing capacity.
- Ensure there is a sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure that all policies are up to date.
- Improve appraisal rates for nursing and medical staff.
- Ensure that consent is clearly recorded on patient records.
- Regularise play specialist provision in paediatric ED.
- Ensure that patient records are stored securely.
- Ensure staff and public are kept informed about future plans for the ED at King George hospital.

Medical Care

- Continue plan to repair breaches in the fire compartmentation as detailed on the corporate risk register.
- Continue to monitor hand hygiene and infection control across all medical wards and follow action plans detailed on the current corporate and divisional risk registers.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.
- Make patient information leaflets readily available to those whose first language is not English.
- Increase staff awareness of the availability of interpretation services.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.

Outpatients and Diagnostics

- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure there is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.

Outstanding practice and areas for improvement

- Ensure the 18 week waiting time indicator is met in the OPD.
- Ensure the 52 week waiting time indicator is consistently met in the OPD.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.
- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We had concerns around the governance of the emergency department including the handling of investigations of incidents, risk management, oversight of resuscitation training, and infection prevention and control management. The service must address this including: 1. Taking action to improve levels of resuscitation training. 2. Ensure there is oversight of the training competencies of locum doctors, particularly around advanced life support training. 3. Take action to improve the response to patients with suspected sepsis. 4. Take action to improve poor levels of hand hygiene compliance. This was a breach of Regulation 17(2)(a) and 17(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed decision making impacted on patient care. The percentage of patients who left without being seen was also higher than the England average in all months between January 2016 and August 2016.

This section is primarily information for the provider

Requirement notices

1. Ensure all patients attending the ED are seen more quickly by a clinician.

This was a breach of Regulation 12(2)(a).