Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's 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
Services for children and young people	Good
Outpatients and diagnostic imaging	Good

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.

Queens Hospital is the trust's main acute hospital and opened as a private finance initiative (PFI) in 2006, bringing together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for people living in Havering, Dagenham and Brentwood. The hospital has over 900 beds, including a hyper acute stroke unit (HASU). The Emergency Department (ED) treats over 150,000 walk-in and ambulance emergencies each year.

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 Queens Hospital of three core services that had previously been rated as inadequate in one or more domain – the Emergency Department (ED), Medical Care and Outpatients & Diagnostics (OPD). We also returned in October to carry out a more in-depth review of the trusts overall leadership and governance, where we also included an announced inspection of Services for Children and Young People (CYP).

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

Our key findings were as follows:

Are services safe?

- Compliance with infection prevention and control (IPC) practices across the services we inspected were found to be inconsistent. IPC standards were observed within services for children and young people (CYP) to be good, including appropriate hand-washing, use of hand gel and personal protective equipment. However, we observed poor compliance in the emergency department (ED) and diagnostics and imaging department, including a lack of consistent hand washing or using sanitising gel between patients. Compliance with standards for infection prevention and control and hygiene including cleaning schedules, decontamination, record keeping and audits required improvement across all services inspected.
- Safety thermometer data submitted nationally did not match the hospital's divisional structure, making it hard to effectively benchmark performance against other trusts.
- Fire safety standards in CYP services, including areas around the NICU were not always maintained. This included variable understanding from staff on emergency procedures, fire doors repeatedly wedged open and a lack of clear signposting for the location of fire extinguishers.
- Medical staff were failing to meet trust targets for completion of mandatory training, across all topics.
- Compliance with resuscitation training in ED was poor and medical staff completion rates in basic life support training were below the trust target.
- Although nursing staffing levels had improved since the last inspection, some medical 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 also reliance on locum doctors across the service.

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- The ED had done a lot of educational work around sepsis and the early identification of a septic patient. Staff understood how to use early warning scores and described how to escalate concerns appropriately.
- Equipment and bedside safety checks were completed and there were procedures in place for staff to obtain technical support in the event of clinical equipment failure.
- Systems were in place to respond to deteriorating CYP patients using the paediatric early warning scores system and availability of a paediatric intensive care transfer service.
- There had been an improvement in the reporting of incidents and the sharing of lessons 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 dispensing and administration of medication on medical wards 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 on medical wards 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.
- The trust had changed their electronic 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.
- Extensive safeguarding systems and processes were in place within CYP services to help identify children and young people at risk of avoidable harm. This included regular multidisciplinary meetings, supervision sessions delivered by the safeguarding team and monthly strategic dashboards that enabled staff to monitor referrals and patient outcomes.
- Staffing levels and skill mix were planned to ensure the delivery of outpatient, diagnostic and imaging services at all times.
- All medicines were found to be in date and stored securely in locked cupboards.

Are services effective?

- We found a number of clinical guidelines on the trust intranet were out of date. There was also issues with access to trust policies and guidelines for agency staff who had no computer access.
- The ED 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.
- Feedback from locum doctors was that training was limited and they felt training for them was not a priority.
- Staff understanding of consent, capacity and Deprivation of Liberty Safeguards (DoLS) was varied.
- Imaging Local Rules for the hospital had not been updated since 2012.
- The standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average.
- Multidisciplinary team working was effective across disciplines. Most staff said they were supported effectively, and they felt valued and respected.
- 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.
- The hospital performed worse than the previous year in both the Myocardial Ischaemia National Audit Project (MINAP) 2013/14 and the National Heart Failure Audit (2013/14). In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures.
- The majority of patients in ED were assessed for pain and offered appropriate pain relief.
- We observed good multidisciplinary (MDT) working between the emergency department (ED) and a number of other services, including psychiatric liaison and the nutritional team.

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- Nursing and medical staff completed a variety of local audits to monitor compliance and drive improvement. Staff told us that these led to meaningful change across the medical service.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for thirteen indicators out of twenty-one indicators.
- The majority of staff received annual appraisals on their performance. Staff were satisfied with the quality of the appraisal process. The trust was supporting nurses with the revalidation process.
- Patients attending the services we visited received care and treatment that was evidence based and in line with best practice.
- The outpatients department and diagnostic and imaging services had introduced clinics Monday to Sunday to clear patient waiting list backlogs.
- CYP services consistently met nine of the ten recommendations in the Royal College of Paediatrics and Child Health Facing the Future 2015 standards, which meant patients received timely and expert care from qualified staff.
- Although there were gaps in the provision of some therapies, including occupational therapy, the hospital had made sustained progress in the increased provision of some services. For example, a paediatric epilepsy nurse had been recruited, a diabetes specialist team was in place and a dedicated paediatric dietician and pharmacist were in post.

Are services caring?

- Patients and relatives across the services told us staff were predominantly kind, respectful and helpful. However, in ED we observed some negative interactions between staff and patients.
- Staff overall provided psychological and emotional support to patients and relatives and could signpost them to other support services if required.
- Bereavement services, were readily available to patients and their relatives. This included a multi-faith chaplaincy service and support from nurses.
- The safeguarding children's assurance group evaluated the feelings of children and young people with a learning disability and their parents and used the results to improve the service.
- In the Friends and Family Test (FFT) the ED scored between 71% and 88% of patients recommending the department to others. This was below the England average.
- Privacy curtains were not being drawn in the main diagnostic and imaging department, and the emergency room in ophthalmology had bays that did not promote patients privacy and dignity.
- The trust performed slightly below the national average in the National Cancer Experience Survey 2015.

Are services responsive?

- The main waiting area and paediatric waiting area in ED were very busy during our second unannounced inspection, and some patients were unable to sit down.
- There was no lead for dementia within the service at the time of our inspection.
- The percentage of patients being seen and treated in ED within the recommended four hour timeframe and number of patients who left the department without being seen was worse than the national average.
- The ED was not meeting its 15 minutes triage indicator for a high proportion of patients. The average time to triage was 28 minutes.
- 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.
- 14% of appointments were cancelled by the hospital. This was higher than the England average of 7.2%.
- Patient information leaflets were not standardly available in languages other than English.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
- Paediatric phlebotomy services were in place to enable blood to be taken from children by staff trained to recognise needle phobia and to use distraction techniques. However, children and young people who needed a blood test were sometimes seen in adult outpatient phlebotomy.
- The ED worked closely with local GPs to ensure they were meeting the needs of the local population.

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- There were a number of specialist teams available such as a frail and older people team, psychiatric support, domestic violence team, and alcohol liaison services.
- There had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016. This reflected an increased effort from the trust to reduce referral to treatment (RTT) times for patients using their services.
- The hospital was using a range of private providers to assist in clearing the backlog of appointments where there were most demand services.
- The outpatients department and diagnostic and imaging services had introduced clinics Monday to Sunday to clear patient waiting list backlogs.
- People living with dementia received tailored care and treatment. Care of the elderly wards had been designed to be dementia friendly. 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. There was a monthly safeguarding and learning disability operations group.
- Catering menus offered many options to cater for those with different nutritional requirements.
- Play specialists were available in CYP services and they provided children with a range of activities. There were three well-equipped play areas available, including a covered outdoor play area.
- A sensory room and mobile sensory equipment was available to help support children and young people with sensory needs, learning disabilities or needs relating to autism.
- A dedicated paediatric learning disabilities nurse had developed a hospital passport for children and visual communication aids. This helped staff to communicate with patients and to understand their likes, dislikes and worries.
- Transition services were in place for children moving into adult services. This included support to gradually build their independence and one-to-one support as they were moved onto an adult pathway.

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.
- Managers and clinical leads were visible and approachable.
- There was evidence staff could confidently provide feedback to the senior team and that changes were considered and implemented where possible.
- Staff were encouraged to engage in research and pilot schemes to drive a culture of change to improve practice and the delivery of patient care
- However, there was no clear vision and strategy for the ED service as we were told plans for the department were constantly changing. Some staff did not know about the departments plans to close King George Hospital accident and emergency department at night.
- Although senior divisional staff had a good understanding of the risks to their respective services as recorded on the risk register; staff responsible for the immediate delivery of clinical care were not always aware of the recorded risks for their service.

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.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which significantly improved the quality of life for families.

Summary of findings

- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

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

Importantly, the trust must:

- Take action to improve levels of resuscitation training.
- Ensure there is oversight of the training done by locum doctors, particularly around advanced life support training
- Take action to improve the response to patients with suspected sepsis
- Take action to improve poor levels of hand hygiene compliance
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.
- Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment
- Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Increase paediatric nursing capacity.
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes
- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Continue to monitor hand hygiene across non-compliant 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.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- 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.

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- 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 the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- 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.
- There is improved access for beds to clinical areas in diagnostic imaging.

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 	There was poor compliance with hand hygiene in the department and the service performed poorly on hand hygiene audits. We observed staff did not wash their hands between patients or when entering and leaving the department. While we found improvements in the number of senior medical staff since the last inspection, the department still had a heavy reliance on locum medical staff to help fill vacancies. However, the trust highlighted that a number of the locum doctors were regular staff members. Compliance with intermediate life support was 55% against a trust target of 85% which was very low. Lack of resuscitation training was rated as high on the corporate risk register. Staff accessed evidence based guidelines and protocols via the trust intranet. We found a number of guidelines, such as ambulatory care guidelines, were out of date and agency staff were unable to log into computers to access clinical guidance. The trust performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock. Staff understanding of consent, capacity and deprivation of liberty safeguards (DoLS) was mixed. Some staff did not know what we meant when we asked about capacity. The total time in the emergency department for the trust was higher than the national average. Between May 2015 and April 2016 the trust medium time in minutes was between 160 and 210 minutes, compared to a national average of between 130 and just below 160 minutes. Patients experienced significant delays in initial assessment and treatment. At the time of the inspection we were told the vision and strategy for the service was still being developed. Staff had a mixed understanding of plans for the department and we received mixed feedback about what had been communicated to staff.

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			However, there were examples of the department working well with other teams within and outside the hospital. Interactions between staff and patients were individual and delivered in a caring and compassionate way. Staff treated patients with dignity and respect in most cases, and kept patients well informed. Since the last inspection improvements had been made to the department's clinical governance and risk management processes.
Medical care (including older people's care)	**Requires improvement**		There had been an improvement in the reporting of incidents and the sharing of lessons from these across the hospital. Staff that we spoke to 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. 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 drive improvement. Staff told us that these led to meaningful change across the service.

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Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain.
In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for thirteen indicators out of twenty-one indicators.
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.
Multidisciplinary team working was effective. Most staff said they were supported effectively and felt valued and respected.
The majority of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
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).
All wards had a performance noticeboard on display which showed the most recent FFT scores.
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.
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.
The average length of stay for all elective and all non-elective patients was below the England average.
People living with dementia received tailored care and treatment. Care of the elderly wards had been designed to be dementia friendly and the hospital

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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.

Catering menus offered many options to cater for those with different nutritional requirements. Posters for communicating with patients with a hearing impairment were displayed on notice boards and deaf awareness training was also offered to staff on all wards.

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.

Infection prevention and control audits, as well as hand hygiene audit results, showed consistently poor compliance in some wards and departments.

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Although most medication was monitored and stored appropriately, we found a pack of pH indicator strips and an anaesthetic cream on two wards which had expired.
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, 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.
There was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
The standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were inappropriate.
For non-elective admissions, the standardised relative risk of readmission was also higher, particularly for clinical oncology.
The hospital performed worse than the previous year in both the Myocardial Ischaemia National Audit Project (MINAP) 2013/14 and the National Heart Failure Audit (2013/14). 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. These results had improved in 2016, but some issues still remained.
The pathways for patients with cancer were not always correctly managed. There was poor communication with tertiary centres, which caused

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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 staff.
Actions were being implemented to improve this.
The pathology service was understaffed and unable to provide effective cover out-of-hours.
The trust performed slightly below the national average in the National Cancer Experience Survey 2015.
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.
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.
The risk register highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards.
Patient information leaflets were not standardly available in languages other than English.
The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
The NHS staff survey results were variable, with the trust still scoring below the national average in many measures.

Services for children and young people

Good

There was clear and sustained improvement from our previous inspection. This included the implementation of an audit programme that led to benchmarking of care standards and improvements in practice.
There was improvement in learning from incidents and how these were communicated with staff, including examples of changes in practice and policy as a result of learning.
Improvements had been made in nurse staffing levels, with an increase in recruitment and a reduction of turnover. Although there was still a vacancy rate of 11% in the nurse team, 15 new staff nurses were due to start and an overseas recruitment programme had been successful in attracting qualified nurses to the hospital.

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Medical staffing levels were consistently good and medical care was consultant-led, with support provided by other clinicians with appropriate training and specialist knowledge.
Safeguarding procedures were robust and embedded in clinical practice and a system of meetings, staff training, supervision and audits acted as checks and balances to ensure children were protected from avoidable harm.
Services were benchmarked against the guidance and standards of national health organisations as a measure of good practice. This included audits of the care received by patients with diabetes and epilepsy. The outcomes of audits resulted in improvements to the service.
Practice development nurses provided support in staff development including competency assessments, training sessions and one-to-one support. In addition, staff were provided with the opportunity to develop specialist link roles. This represented part of a broader programme to encourage staff training and development.
A weekly multidisciplinary psychosocial meeting ensured patients with complex needs or those who needed community social support were reviewed by a specialist team. Staff used this meeting to plan complex discharges, review safeguarding alerts and ensure care and treatment met individual needs.
Feedback from patients and their parents was consistently good in the trust's in-house 'I want great care' survey. Staff demonstrated kind, compassionate and friendly care in all of our observations and all of the parents we spoke with told us they were happy with the service.
Services were planned to meet the needs of the local population. This included Saturday outpatient clinics, a daily phlebotomy service and a weekly visit from a peripatetic local authority school teacher.
Two dedicated play specialists and two play workers were available in Tropical Bay and Tropical Lagoon wards and children had access to a range of activities, equipment and toys. This included two indoor play areas and a secure outdoor play area attached to Tropical Lagoon. A sensory room and mobile sensory equipment were also provided.
A dedicated paediatric learning disability nurse had introduced support resources for patients, including

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a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.

Transition services were in place for when a child moved into adult services. This was a structured approach that provided patients with gradually increasing levels of independence followed by the support of both children's and adult's nurses as they moved.

Clinical governance structures enabled staff to monitor risks to the service and involve patients and staff in improvements. This was achieved through various means including a patient safety summit, clinical safety and quality meetings, whole unit team meetings and the use of a risk register to track changes in risk status.

Changes to leadership in children's services had been well received by staff and as part of the trust's ongoing improvement programme, a new lead nurse was due to join the hospital in January 2017 with a remit of improving communication between hospital services and the care of young people.

Staff were encouraged to provide feedback on their work and hospital policies and this was acted upon. In addition, staff with an interest in research were supported to participate to help inform innovative practice.

However, environmental safety and waste management standards were not always consistent. This was because access to areas used to store sharps bins and waste was sometimes uncontrolled and there was a lack of compliance with fire safety guidance in some areas.

Multidisciplinary staff did not attend nurse and medical handovers or ward rounds and short staffing in therapies teams meant there was inconsistent input from physiotherapy and dietetics and no occupational therapy service. This was evident in the inconsistent standards of nutrition risk assessments in patient records.

Local audits identified documentation of consent to treatment as an area for improvement. Nursing staff were aware of this and handovers included a discussion of which patients had consent forms completed.

Summary of findings

Outpatients and diagnostic imaging

Good

There was evidence of significant 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.

Summary of findings

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.
However , we also found:
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.
We found alcohol hand sanitising gel dispensers in the ground floor outpatients waiting area and diagnostic and imaging department entrance were empty. Staff in the diagnostic and imaging department did not observe best practice guidance on hand washing or using sanitising gel between patients. The first floor outpatients' department corridor was being used as a waiting area and this created a risk due to patients waiting in the corridor.
Privacy curtains were not being drawn in the main diagnostic and imaging department, and the emergency room in ophthalmology had bays that did not promote patients' privacy and dignity.
Phlebotomy waiting rooms were full and there appeared to be limited space for the phlebotomy service's footprint to expand.
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 standard for patients waiting less than 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.

Summary of findings

Some staff in the diagnostics and imaging team said there was a lack of clarity around their roles and responsibilities.

Queen's Hospital

Detailed findings

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

Detailed findings

Contents

Background to Queen's Hospital

Queens Hospital is the trust's main acute hospital and opened as a private finance initiative (PFI) in 2006, bringing together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for people living in Havering, Dagenham and Brentwood. The hospital has over 900 beds, including a hyper acute stroke unit (HASU). The Emergency Department (ED) treats over 150,000 walk-in and ambulance emergencies each year.

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 Queens Hospital of four core services that had previously been rated as inadequate in one or more domain – the Emergency Department (ED), Medical Care, Children and Young Peoples Services 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.

Detailed findings

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

We initially carried out an unannounced focused inspection of key core services at both Queens Hospital and King George 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	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at Queens Hospital comprised of an accident and emergency (A&E) department, an urgent care centre, and a dedicated children's A&E department in an area within the main department. It treats people with serious and life threatening emergencies. The A&E provides a 24-hour, seven day a week service.

People with less urgent problems and those with minor injuries are treated in the urgent care centre until midnight. The trust has one of the highest attendances in England with 274,991 people attending the hospital between April 2015 and March 2016. Of these 20.3% resulted in an admission which was less than the England average of 21.6%.

The department has an eight bay resuscitation room with two bays designated for children, The major treatment area has 25 trolley bays and the children department has 10. There is a treatment area called 'majors lite' which has seven patient trolleys. There is a dedicated room suitable for the assessment of people with acute mental health issues. There is no designated health-based place of safety for people detained under section 136 of the Mental Health Act at the hospital. The department was previous inspected in March 2015 and was rated as inadequate for safe and requires improvement for effective, caring, responsive and well led.

We visited the department on 7 September 2016 and returned on 3 October 2016 as part of series of unannounced inspection. We spoke with 15 patients and their families and 42 members of staff which included doctors, nurses, nursing assistants and a number of senior leaders in the department.

Urgent and emergency services

Summary of findings

We rated the service overall as requires improvement because:

- There was poor compliance with hand hygiene in the department and the service performed poorly on hand hygiene audits. We observed staff did not wash their hands between patients or when entering and leaving the department.
- While we found some improvements in the number of senior medical staffing since the last inspection, the department still had a heavy reliance on locum medical staff to help fill vacancies. However, the trust highlighted that a number of the locum doctors were regular.
- Compliance with intermediate life support was 55% against a trust target of 85% which was very low. Lack of resuscitation training was rated as high on the corporate risk register.
- Staff accessed evidence based guidelines and protocols via the trust intranet. We found a number of guidelines, such as ambulatory care guidelines, were out of date and agency staff were unable to log into computers to access clinical guidance.
- The trust performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock.
- Staff understanding of consent, capacity and deprivation of liberty safeguards (DoLS) was mixed. Some staff did not know what we meant when we asked about capacity.
- The total time in the emergency department for the trust was higher than the national average. Between May 2015 and April 2016 the trust medium time in minutes was between 160 and 210 minutes, compared to a national average of between 130 and just below 160 minutes.
- Patients experienced significant delays in initial assessment and treatment.
- At the time of the inspection we were told the vision and strategy for the service was still being developed. Staff had a mixed understanding of plans for the department and we received mixed feedback about what had been communicated to staff.

However:

- There were examples of the department working well with other teams within and outside the hospital.
- Since the last inspection improvements had been made to the department's clinical governance and risk management processes.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Senior leaders told us at the time of the previous inspection the service had a backlog of incident investigations. Data provided by the trust showed there were 10 SI's which had breached their internal deadline.
- We observed poor compliance with infection prevention and control (IPC) practices. We noted a number of staff did not wash their hands between seeing patients or when entering or leaving the department. Hand hygiene audits showed compliance to be poor, with only 60% compliance for August 2016. Cleanliness stickers were not consistently being used across the department so we were unable to determine which equipment had been cleaned.
- Senior leaders were aware of the issue around nursing vacancies, particularly the high band 6 vacancy rate. The department had over-recruited band 5 nurses to compensate for the lack of band 6 nurses, and management of the department supported band 5 staff to act up into band 6 roles through in-house training, individualised action plans and development opportunities. Band 5 nurses acting up were provided with regular supervision from the band 7 team leader.
- There was high usage of locum medical staffing for consultants and middle grade doctors.
- In addition, feedback from some locums was that access to training was poor and we had concerns that this meant they might not be appropriately skilled with up to date competencies.
- Compliance with resuscitation training was poor and we had no assurance that locum medical staff had up to date resuscitation training. This was on the divisions risk register as it meant patients were at risk.

However,

- Since the previous inspection in March 2015 the department had done a lot of work around incident reporting. Staff had a good understanding of the types of things they should be reporting as incidents. There was also regular feedback regarding incidents.
- Staff had a good understanding of their roles and responsibilities with regards to safeguarding adults and children.
- The department had done a lot of educational work around sepsis and the early identification of a septic patient. Staff understood how to use early warning scores and described how to escalate concerns appropriately.

Incidents

- The trust reported to the Strategic Executive Information System (STEIS), which records Serious Incidents and Never Events.
- The service reported no never events 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. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurring for that incident to be categorised as a never event.
- Incidents were reported via online forms that could be accessed by permanent staff on any trust computer. However, agency staff had no access to trust computers and relied on permanent staff to complete incident forms for them.
- The ED department reported 751 incidents between April 2016 and September 2016. Of the 715 incidents 188 were reported as no harm (25%), 366 as low harm (48.7%), 142 as moderate harm (18.9%), 16 as severe harm (2.1%) and three (0.4%) as catastrophic (death). The remaining 36 (4.8%) were reported as near miss incidents.
- Serious incidents (SI) are those that require investigation. Between September 2015 and September 2016, the service reported 13 serious incidents. We looked at three reports and saw evidence of investigation and root cause analysis (RCA), including action points.
- Senior leaders told us at the time of the previous inspection the service had a backlog of incident investigations. Data provided by the trust showed there were 10 SI's which had breached their internal deadline.

- Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.
- Staff received feedback and learning points from incidents, including those that occurred within the hospital and other sites within the trust. Learning was shared via email and the daily staff meeting at 7:30am each morning.
- We received mixed feedback from staff regarding learning from incidents. Some staff were able to describe action points form incidents. For example, some staff told us there had been an incident where a child had deteriorated in the paediatric waiting area. This had resulted in a glass panel being inserted into the door so staff could see into the waiting area and regular checks were conducted. However, some staff were unable to give examples of learning from incidents and changes in practice as a result.
- Hospital-wide 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.
- Morbidity and mortality (M&M) meetings were held on a monthly basis. We reviewed two sets of minutes and saw the ED was represented in one of these meetings.
- 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.
- Staff understood the term 'duty of candour' and their responsibilities related to this, especially with regards to being open and transparent with patients and relatives.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for hand hygiene and infection prevention and control.
- We looked at hand hygiene audit data between August 2015 and August 2016 which showed compliance was very poor. For example, in July 2016 and August 2016 compliance was 68% and 60% respectively. Compliance went as low as 41% in January 2016.
- There were dispensers with hand sanitising gel situated around the ED. However, at the time of our inspection a number of these were observed to be empty. We noted these were refilled before the end of the day.
- 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. We observed poor infection control practice in some areas whereby staff did not wash their hands in between seeing patients.
- The trust performed worse than the England average on the A&E survey indicators relating to cleanliness.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be used. We saw stickers had been marked with the date the item had been cleaned and observed staff replacing stickers once they returned the clean equipment. However, use of these stickers was not consistent. We found six observation and electrocardiogram (ECG) machines lined up for use in cubicles and only one of them had an 'I am clean sticker'. ECG is a test that is used to check a patient's heart rhythm and electrical activity.
- We inspected various pieces of equipment such as commodes and found a good level of cleanliness.
- Cubicles viewed by us during the inspection were clean with no high or low-level dust. Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them.
- The ED departments' main entrance and surrounding pathways were clean and uncluttered.
- There were adequate supplies for personal protective equipment (PPE) available and we saw staff using this appropriately when delivering care. We noted that staff generally adhered to the "bare below the elbow" guidance in clinical areas.

Safety Thermometer

- The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence.
- The service reported one fall with harm in the monthly safety thermometer survey. At the time of the inspection

we found the emergency department was displaying the number of falls on the quality of care board in the main waiting area. There was two falls with no harm reported in August.
- During our unannounced inspection in October 2016 a patient tried to get out of bed and had a fall. The nurse reported this to the nurse in charge and was told to complete an incident report.
- The service was not displaying any other safety thermometer information.

Environment and equipment

- The major treatment area was circular in design with a large staff base in the centre. This enabled staff to observe patients at all times.
- There was a side room in the majors area which was designated as a 'sepsis bay'. This room was also available for patients who presented with possible cross-infection risk.
- There was a dedicated x-ray unit within the department, which staff said was easily accessible.
- We checked two trolleys and mattresses and all were clean. There were no tears in the mattresses, and brakes and cot slides were in working order.
- There was a secure room for mental health patients. The furniture was secured to the floor, and there were no ligature points. The room had two doors, which met standards set out by the Psychiatric Liaison Accreditation Network (PLAN).
- The main waiting area in the ED was bright, airy and well maintained.
- Patients were advised to wait behind a red line in the main ED reception whilst waiting to register to ensure patient privacy was maintained.
- There was a separate waiting area for children which contained a selection of toys suitable for different ages of children. There was also a television which played age appropriate cartoons and programmes throughout the day.
- The children's waiting was small and a number of seats were situated next to the reception desk. This meant that patients could be overheard whilst registering by those seated nearby.
- During our unannounced inspection, we noted the paediatric waiting area was full and some parents were standing with their children.
- The department had a wide range of specialist equipment which were clean. We saw equipment had labels to show it had undergone a safety check in the last year.
- The resuscitation area had eight bays, one of which was a dedicated paediatric bay and one which could be used as either an adult or paediatric bay. Records we looked at showed the paediatric resuscitation trolley was checked twice daily for broken seals and the entire contents was checked weekly. We also looked at records for the resuscitation trolley in the trauma bay and saw this was checked daily.
- Records we looked at for two sepsis trolleys showed they were meant to be checked on a daily basis. One sepsis trolley in the resuscitation area had missed four checks and the second trolley in the Rapid Assessment and Treatment (RAT) area had missed three checks in the last month.
- Needle sharp bins were available and all bins we inspected were correctly labelled and dated. We found one sharps bin which was filled above the line the maximum fill line. This was raised with the service and removed.

Medicines

- Medicines were stored securely inside locked medicine cupboards which complied with the trusts medicine management policy. In the majors area there were two sets of keys, green keys for medication cupboards and red keys for controlled drugs (CDs).
- CDs were stored and administered in line with National Institute for Health and Care Excellence (NICE) guidance, including the double locking of cupboards and the practice of two nurses checking in CDs. We saw evidence of second signatures, total balances maintained accurately when being moved from page to page and the appropriate storage of these medicines. Stock checks of controlled drugs were completed daily.
- Medication fridges were locked and temperatures checked and recorded. Fridge temperature checks were completed on a daily basis and there were written instructions informing staff how to escalate if temperatures fell out of range.
- There was antibiotic guidance available on the intranet and doctors showed us how they accessed this. The policy was in date.

- We observed staff administrating intravenous fluids (IV) safely and correctly. Two nurses signed the medication chart to confirm it had been given.
- The pharmacy team completed stocks checks in the emergency department twice a week and IV medication checks were done three times a week.
- During our unannounced inspection we found a blue medication tray was left on the side of the nursing station unattended. This was there for around 10 minutes before it was removed. The medication tray contained a number of antibiotic medications and sodium chloride.

Records

- Patients were registered on the computer system and a paper record was generated by reception staff registering the patient's arrival in the department and was used to plan and record a patient's treatment.
- An electronic patient system ran alongside paper records which allowed staff to track patients' movement through the department and to highlight any delays. Staff used the computer system to record details of the initial clinical assessment, referrals, and investigations such as x-rays.
- We looked at 13 sets of patient records to check that timely care was given to patients and the department was routinely carrying out risk assessments such as for pressure ulcers.
- We found allergies were clearly documented in all cases.
- We reviewed records for the completion of early warning scores and found National Early Warning Scores (NEWS) were completed in all cases.
- Pain scores were recorded in all 13 notes we looked at and analgesia was prescribed where appropriate.
- Where applicable, appropriate antibiotics were prescribed and administered.
- The department audited record keeping each month. Between February and August 2016 compliance varied between 76% and 100%. 94% of staff had completed information governance training against a trust target of 85%.

Safeguarding

- The trust provided us with records that showed compliance for Queens ED staff was 100% for safeguarding adults level one, 95% safeguarding adults level two, 100% for safeguarding children level one and 78% safeguarding level three. For paediatric ED the completion rate for safeguarding adults level two and safeguarding children level three were both 94%. For medical staff completion rates for safeguarding adults level two (70%) and safeguarding children level 2 (72%). These were against a trust target of 85%.
- The safeguarding adult and children policies were available on the trust intranet and were up to date.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding adults and children. Staff were able to give us examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.
- All staff we spoke with knew the safeguarding team and could identify where to find the contact details if required. Staff showed us how they accessed the safeguarding policies on the trust intranet, which were in date.
- The department had a positive focus on child safeguarding. All children who attended were checked via a mandatory screening tool during triage. This was followed by a further assessment by the assessing clinician and a final safeguarding check prior to discharge. There was also an injury assessment flow chart which clinicians completed when young people presented at the ED with an injury.
- We looked at the child protection pathway which gave staff guidance on what to do should they have concerns. Staff were able to describe this process which included completing the multi-agency referral form (MARF).
- A mental health liaison team, including psychiatric liaison nurses and a consultant, worked with the ED team to provide specialist mental health, safeguarding and capacity assessment support.
- Staff had a good understanding of female genital mutilation (FGM) and knew they could access the safeguarding lead for any support.
- The service had an interim emergency department safeguarding nurse who reviewed all safeguarding concerns to ensure staff had actioned them appropriately.

Mandatory training

- Mandatory training included topics such as fire training, health and safety, infection control, and manual handling. Training took place on-line and face to face during staffs induction.

- The trust provide a training matrix of mandatory training courses completed across ED. The data provided showed that for nursing staff Queens ED were meeting the trust target of 85% completion for conflict resolution (89%), equality, diversity and human rights (97%), fire safety (92%), health safety and welfare (98%), infection prevention and control (IPCX) level one (100%) and level two (93%), moving and handling level one (100%) and level two (90%).
- Resuscitation level two Basic Life Support (BLS) for adults was 81% and level two paediatrics was 82%, both below the trust target if 85%.
- Resuscitation level three Intermediate Life Support (ILS) training for adult compliance was 55% against a trust target of 85%.
- The paediatric ED training figures included both Queens Hospital and King George. The only training not meeting the trust target was resuscitation training level two BLS paediatric (82%).
- For medical staff completion rates for conflict resolution (63%), fire safety (82%), IPC aseptic non touch technique (75%), resuscitation level two BLS paediatrics (80%) were below the trust target of 85%.
- We were told that locum medical staff were provided via a third party organisation which was responsible for ensuring that all staff had appropriate training, including resuscitation training. The Trust said this was confirmed on an induction checklist when the member of staff presented to work. However, the trust was unable to supply us with data to evidence the fact that they were assured all locum had appropriate resuscitation training.
- Each staff member could access the BHRUT Education Staff Training (BEST) system. This system allowed staff to view their training records to see when training expired and needed updating.
- The ED had practice development nurses (PDNs) who were responsible for planning mandatory training for staff.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (‘blue light’) were transferred immediately to the resuscitation area. The ambulance service called the hospital in advance to ensure the teams were alerted and could plan accordingly. Staff completed the ‘priority blue call form’ and recorded all the required details. Once the crews arrived at the resuscitation area there was a bell to press which alerted staff of their arrival.
- Staff in the rapid assessment and treatment area assessed lower priority patients arriving by ambulance after receiving a handover from the ambulance crew. The aim of this area was for a senior doctor to rapidly assess and initiate treatment for the sickest patients. This helped the service to prevent and minimise harm.
- Ambulance turnaround did not meet the national indicator for handover of 15 minutes. However, between June 2015 and May 2016 there were 27,068 (67%) ambulances with a turnaround of more than 30 minutes. Of these, 11.5% were delayed over 60 minutes, known as a black breach. The trust performed worse than the England average on the A&E survey indicator relating to ambulance handover time.
- We observed numerous ambulance handovers during our first inspection and saw ambulance crews were seen within the recommended time of 15 minutes. We spoke to three ambulance crew members during our second unannounced inspection and was told generally the handovers were quick at Queens hospital.
- From June 2015 to September 2016 the trust did not always meet the 60 minute time to treatment national indicator. On average patients waited 188 minutes from registration to treatment. The trust median time to treatment was consistently worse than the England average and the national standard.
- Walk in patients registered with a receptionist. There were nurses allocated to do the initial triage of patients. Triage is where the nurse will determine the seriousness of the patient’s condition and make plans for their ongoing care. Royal College of Emergency Medicine (RCEM) guidance recommends patients to be seen by a clinical practitioner for initial assessment within 15 minutes of arriving in an Accident and Emergency (A&E) department. On the day of our first inspection we saw patients were being triaged within 15 minute time frame. During our second unannounced inspection we checked records of 13 patients for triage times and only one patient had to wait longer than 15 minutes. However, trust data showed between June 2015 and September 2016 patients waited on average 28 minutes to be triaged.
- The ED was also using medical or nursing ‘streamers’ who assessed patients in the waiting area and, if

appropriate, sign posted patients to other services, such as the Urgent Care centre (UCC). This helped to keep people out of the emergency department when it was not required.

- The emergency services had an operational sepsis pathway for patients and sepsis screening was routinely carried out by staff and recorded in patient records. The quality board displayed in the waiting area showed sepsis screening compliance for August was 85.7%.
- The trust had done a lot of work around the sepsis pathway. Posters were up around the ED called 'Management of Adult Sepsis Patients in Queens ED – Journey of Improvement'. Trust data showed that in quarter one (April till June) only 46% of patients were getting antibiotics within one hour of arrival in ED. In quarter two (July till September) this had increased to 70%.
- During the inspection we looked at 13 patient records for completion of National Early Warning Stores (NEWS) and Paediatric Early Warning Scores (PEWS). We found all 13 records had completed NEWS/PEWS scores. Staff were able to describe what scores on NEWS/PEWS would trigger the sepsis pathway. If a patient scored five or more this would be escalated to senior doctors and a sepsis proforma would be completed.
- The paediatric department had developed a sepsis screening tool for paediatric patients and incorporated it into the paediatric ED card. At the time of the inspection this was going through governance for approval.
- Between December 2015 and August 2015 the ED majors was audited for completion of NEWS assessments. Compliance varied between 73% and 98%, with an average of 88%.
- Nurses were inconsistent in their practice in recording risk. For example, skin integrity and falls assessments were not carried out in all relevant cases.
- After booking at the main reception, children were immediately directed to a separate children's waiting area. Two nurses carried out child triage and this included a pain score. If a doctor had a concern about child safeguarding they would contact the safeguarding team and social care while the child was in the department.

Nursing staffing

- There were three morning nursing shift start times – 7:30am, 10am and 11am, and staff were flexed up and down as activity dictated.
- The majority of the nurses we spoke with said staffing numbers were one of the biggest challenges in the department. However, nursing staffing numbers was not on the departments risk register.
- Data provided by the trust showed that the total establishment for bad 5 nurses was 67.5 WTE and the department currently had 58.4 WTE in post. This meant the vacancy rate for band 5 nurses was 14%. For band 6 nurses the total establishment was 42.3 WTE and there were 22.6 WTE in post, meaning the vacancy rate was 47%.
- We were sent staffing fill percentages for May 2016 to August 2016 and the fill rate was between 84% and 95%, with August having the lowest fill rate for staff.
- Queens ED utilised a 'staffing daily risk assessment' which allowed the nurse in charge to undertake a daily assessment of actual staff number versus template. The nurse completed an initial daily review of patient acuity and dependency based on number of patients in the department and acuity of patients in the resuscitation area. This was then compared to the daily staffing numbers and skill mix to analyse the level of risk to staff and patients. For example, if a shift was down by four nurses this would be a 'black' risk on the trigger tool.
- During the second unannounced inspection we saw that the ED was very busy. The nurse in charge deployed staff to busier areas of the department with the aim to bring down the waiting times.
- The ED did not assess staffing levels and skill mix based on the Royal College of Nursing (RCN), Emergency Care Association (ECA), and the Faculty of Emergency Nursing (FEN) recommendations. RCN guidance recommended two registered nurses to one patient in cases of major trauma or cardiac arrest and one registered nurse to four cubicles in either major or minor trauma.
- At Queens hospital, the trust established nurse to patient ratio at 1:2 for resuscitation room which did meet the RCN recommendations. For major and minor area, the nurse to patient ratio was 1:5 and did not meet the RCN recommendations.
- The trust had introduced armbands which the nurse in charge wore so they were easily identifiable.
- National standards for children and young people in emergency care settings state that there must be a nurse with advanced paediatric life support

qualification on each shift. Queens ED had seven paediatric nurses trained in paediatric life support (PLS) who worked across both hospitals. Trust data for the past three months (August to October) 29 out of 84 shifts did not have a nurse with advanced paediatric life support training, which equates to 35% of shifts not meeting the national standard.

- We saw the lack of adequate paediatric nursing capacity was rated as high on the recent corporate risk register.
- The clinical lead told us five nurses were starting paediatric training to increase the number of paediatric nurses in the department. The department was also running paediatric training days to educate staff.
- Nursing staff new to the department told us they experienced a robust initial induction. The 'ED nurse orientation pack' provided a comprehensive introduction to the department.
- The paediatric ED had nursery nurses however there were no designated play specialists.
- There was an induction checklist for agency nurses working in the A&E department, which needed to be signed and dated by the agency staff.
- Agency and bank usage from June 2016 and October 2016 varied from between 19.1% and 26.2%.

Medical staffing

- There were 18 consultants posts within the department and 12 of these posts were filled by permanent staff. All 12 consultant medical staff were shared with King George Hospital.
- Locum consultants were employed to boost numbers and accounted for the remaining six posts (33%).
- Data supplied by the trust showed that there was a 40.6% vacancy rate amongst medical staff, with the largest vacancy rate for consultants (46%), SHO's (18.8%) and middle grades (59%).
- During the week and weekend the emergency department had consultant cover between the hours of 8am and till midnight. This ensured the department was meeting the RCEM standard around consultant presence. The RCEM states that there should be a consultant present for a minimum of 16 hours a day. The department had recently introduced consultants who worked during the night, which meant on some days there was 24 hour consultant presence.
- A paediatric emergency consultant covered the paediatric ED between the hours of 8am and 5pm, with cover available on certain days until 10pm.
- Junior doctor cover included eight doctors working between 8am and 8.30pm, which included registrar and senior house office (SHO). There was an additional registrar working from 8am to 4pm on a short day. The twilight shift between 11am and 11pm had six doctors and the night shift between 8pm and 8:30am had seven doctors.
- The department also had two paediatric clinical fellows and four paediatric middle grade doctors who provided cover from 8am to midnight across the week.
- There was a lower proportion of consultants and a higher proportion of junior doctors in the department compared to the England average.
- Data provided by the trust showed that there was a high usage of locum staff for junior doctor, middle grade doctor and consultant shifts.
- Between July 2016 and October 2016 middle grade doctor shifts filled by permanent staff varied from 27% to 51%. Senior leaders told us there were challenges in recruiting middle grade doctors to the department. During our second unannounced inspection we looked at the junior doctor rota and noted there was a high usage of locum staff. For example, on the 2nd October there were 10 locums working during the day.
- Between July 2016 and October 2016 consultant doctor shifts filled by permanent staff varied from 39% to 57%. This showed that for some weeks a high percentage of shifts were filled with locum staff.
- We spoke to some locums during the inspection who told us they could not access training in the same way junior doctors could. We were told since the junior doctors had left the weekly training sessions had stopped taking place. This meant there were no assurances that their clinical skills were up to date. One member of staff told us their advanced life support training was out of date, which poses a significant risk when treating cardiac arrest. We asked the trust how they monitored whether locum staff had up to date advanced life support training. We was told this was done via a third party and the trust were unable to provide us with assurance that locum staff had appropriate resuscitation training.

Major incident awareness and training

- The hospital had an up to date major incident plan. This provided clinical guidance and support to staff on treating patients with a range of injuries resulting from major incidents.

Urgent and emergency services

- We inspected the major incident room and noted the ED had recently remodelled 'injury specific' packs. The packs were for things such as burns, gunshot wounds and injuries by toxic substance. All contents and equipment was in date and recently audited. There were new portable blood pressure monitoring screens and a decontamination tent visible. There were CBRN suits which are a form of personal protective equipment to protect against radioactive, biological or chemical substances. These suits had recently been audited and were in date. The room also had a dedicated service outlet with water and electricity outside the equipment room in the decontamination area.
- Staff told us they had received major incident awareness training and we were told by the senior team that a major incident training programme had been initiated. We were told this was a rolling programme, by the end of which all staff should have received one and a half days of training Data provided by the trust showed that out of 258 members of staff who could work at Queens ED a total of 59 (22.8)have been trained in the past 12 months.
- The ED was trying to get the programme accredited as a clinical practice development (CPD) course to make it more of a priority. The training was not mandatory, however the forward plan was to undertake a full training needs analysis and ensure a mandatory programme of training. This would be aimed at different levels according to need/role likely to be undertaken in the event of a major incident. This would include face to face training, distance learning (e.g. training/testing videos) and will be recorded on the BEST system.
- Staff showed us how to access the major incident plan and action cards on the trust intranet page. There were also frameworks for mass casualty, infectious diseases and threat specific guidance readily accessible on the intranet.
- Staff we spoke with were able to describe the process to follow in the case of a major incident.
- Security staff walked round the ED throughout the day, all staff had received conflict resolution training.
- During the first inspection in September we did not see security staff walking through the department on a regular basis. However, during the unannounced inspection in October we noted the security staff were present and regularly walking around the department.

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 also 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.
- Feedback from locum doctors was that training was limited and they were not a priority.
- Staffs understanding of consent, capacity and Deprivation of Liberty Safeguards (DoLS) was varied.

However:

- The majority of patients were assessed for pain and offered appropriate pain relief. We found pain assessments had been completed in all of the patient records we looked at during the inspection.
- The department ran multidisciplinary keeping in touch (KIT) days in order to provide staff with training for their development.
- We observed good multidisciplinary (MDT) working between the emergency department (ED) and a number of other services, including psychiatric liaison and the nutritional team.

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.

- There were specific pathways for certain conditions such as sepsis and head injuries. Staff displayed good knowledge of treatment options when treating patients who had sepsis. We saw the 'Sepsis Six' protocol was being used by clinicians in patient notes.
- We saw examples of evidence-based audits and care pathways including for a fitting child, and for asthma in children. The clinical lead for audits confirmed current local audits included the septic shock, and asthma in children.
- The trust had conducted an audit looking at VTE prophylaxis in lower limb immobilization in plaster case for lower limb injuries in ED. Results showed that 68% of patients had no documented VTE assessment in their notes and only 30% mentioned whether or not a patient required thrombophylaxis. There was also no documentation of referral for thrombophylaxis treatment in the majority of cases. Therefore, the department was not meeting the guidance set by the RCEM. As a result, the trust introduced education around this to the junior doctor and ENP induction, attached a VTE booklet to patients booking in with lower limb injuries and generated an information leaflet for patients to provide an understanding of VTE.
- Staff showed us how they would access local guidelines on the trust intranet. Full time staff told us that clinical guidelines were easily accessible. We were told guidelines and pathways were available on a downloadable mobile phone application.
- However, agency staff did not have access to the computer terminals in the department which limited their access to trust protocols and guidelines. There was no other way to access guidelines.
- We looked at eight sets of guidelines on the trust intranet page and all of them were out of date. This included a number of ambulatory care guidelines including acute asthma in adults, suspected giant cell arteritis, deep vein thrombosis (DVT), pneumothorax, lower risk upper GI, pulmonary embolism and cardiac chest pain. We looked at the traumatic head pathway, adult sickle cell protocol and acute medium respiratory which were also all out of date.

Pain relief

- The trust scored similar to other trusts in the A&E survey 2014 related to pain relief being offered to patients.
- Patients were assessed for pain on a regular basis as part of basic observations using a formal patient reporting scoring system. We observed patients in triage and they were asked to indicate their pain level on a scale of 1 to 10 and offered pain relief accordingly.
- Children's pain was assessed based on children's own reporting of pain, for example, the Wong Baker FACES pain rating scale where children used faces to best describe their pain.
- We checked 13 sets of patient notes, which showed staff had recorded pain scores and followed up appropriately. Staff noted when analgesia had been offered and whether the patient had accepted it or declined it.
- The majority of patients we spoke with told us they had been offered pain relief. However, one patient in the majors department told us they had requested pain relief numerous times and the nurses had not responded. We escalated this to the nurse in charge and the patient was given pain relief.

Nutrition and hydration

- The trust scored similar to other trusts in the A&E patient survey 2014 related to availability of food and drinks.
- The service had a system in place called 'comfort rounds' which took place every couple of hours. This was to ensure patients were regularly offered drinks and snacks and to see if they needed to use the bathroom.
- We saw that patients being assessed or treated were offered tea, coffee, water and snacks.
- We asked seven patients if they had been offered food and drink. Six people said they had been offered something and one person said they were thirsty and had not been offered anything.
- We observed staff following NICE guidance for the for the administration of intravenous fluids (IV).

Patient outcomes

- The department participated in RCEM audits so that it could benchmark its practice and performance against best practice and other A&E departments.
- In the 2013/14 audit of severe sepsis and septic shock the department performed worse that than the England average in eight of the twelve indicators. In 30% of cases high flow oxygen was administered within the ED and 80% of patients vital signs were measured and recorded in the ED. In 60% of cases capillary blood glucose was

measured and recorded on arrival. The department was expected to meet the standard of 100%. The requirement that 50% of patients were administered antibiotics in the ED within one hour was not achieved as the department provided this in 32% of cases. The first IV crystalloid fluid bolus was given in the ED within one hour in 38% of cases, compared to the RCEM standard of 75%. In 26% of cases, there was evidence that blood cultures were obtained within the ED and 18% evidence that urine output measurements were instituted, compared to the 100% standard.

- In the RCEM Asthma in Children 2013-2014 audit, the department scored lower than the England average in three indicators. These were related to initial observations of systolic blood pressure (0%)and peak flow (4%) and Beta 2 agonist treatment given within 10 minutes of arrival (2%). The department was expected to meet the standard of 100%. However, the department performed than the England average in four indicators including initial observations of oxygen saturation (78%), pulse (78%), temperature (74%) and IV hydrocortisone or oral prednisone treatment (82%).
- 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%). The proportion of cases that received N-acetylcysteine (NAC) within one hour of arrival for patients whose dose was less than 6kg and over eight hours since ingestions and staggered overdoses were both 0%. The department was expected to meet this standard in 100% of cases.
- In the RCEM initial management of the fitting child 2014/15 audit the department performed similar to the England average. However, it did not meet the fundamental standards that all patients should have their blood glucose checked and documented. The department achieved this in 50% of cases compared to the RCEM recommended standard of 100% of cases.
- Queens hospital generally performed similar to the England average in the RCEM mental health in the ED audit. However, the department did not meet the fundamental standard that all patients should have a risk assessment taken and recorded in their clinical record. This only happened in 66% of cases compared to the recommended standard of 100%.
- Queen's Hospital performed worse than the England average in two out of five applicable indicators in the RCEM assessing cognitive impairment in older people audit. In 4% of cases a cognitive assessment took place compared to the RCEM recommended standard of 100%. The department also did not meet the fundamental standard that all patients should have an early warnings score documented.
- The department audited the recording of vital signs in children and found 51% of children had a set of vital signs recorded in the notes within 15 minutes of arrival. According to the RCEM the department was expected to meet this in 100% of cases. Recognition of abnormal vital signs by the ED clinician only occurred in 14% and acted upon in 51% of cases, against a standard of 100%. A complete set of abnormal vital signs was only recorded in 2% of cases, which compared poorly to the national median and RCEM standard. Children with persistently recorded abnormal vital signs had documented evidence of review by a senior doctor in only 29% of cases, again below RCEM standards. As a result of the poor performance in this audit the department had a clinical audit action plan in place to improve the recording of vital signs.
- The unplanned re-attendance rate (number of patient re-attending within seven days of a previous attendance at A&E) between May 2015 and April 2016 was between 10% and 11%. This was consistently worse than the England average of 7.6% and worse than the national standard of 5%.
  - 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.

Competent staff

- Records provided by the trust showed for Queen's main ED (79%), medical staff (60%) and paediatrics ED (88%) had completed their appraisals against a trust target of 85%.
- We observed that clinical practice by both doctors and nurses was within published guidelines. Staff demonstrated a good level of knowledge and understanding of evidence based practice. They were aware of NICE and RCEM guidelines.

- A practice development nurse (PDN) was responsible for the professional development of the staff. Staff told us they used the BHRUT education staff training (BEST) system as a way of ensuring training was up to date.
- We observed a 'skills and drills' training session led by a consultant. This was a weekly session open to all staff and grades and involved simulation training. We observed simulated resuscitation of a baby. Simulation training days usually go through scenarios that have happened within the department.
- Each team within the department had Keep in Touch (KIT) days four times a year. KIT days included training around a range of subjects such as tissue viability and resuscitation. The days were multidisciplinary and often involved teaching from different areas of the hospital. Staff were positive about the KIT days and said they were good for team building.
- The department ran a paediatric emergency units training day every couple of months. This was a full training day for staff and included a range of different teaching topics such as child sexual exploitation, paediatric clinical governance, burns in children and paediatric sepsis.
- We saw evidence that agency staff received an induction. For example, records showed that 30 out of 30 agency staff had all completed their induction. The service also required agency staff to complete a medication managements pack, however at the time of the first inspection we saw no evidence that any of the 30 staff had completed this.
- The department had appointed an academic lead to ensure trainees were getting the right levels of support. There was dedicated teaching time each week to ensure trainees reach all of their competencies. The academic lead told us in the future the weekly teaching time will be structured to fit with the trainees teaching programme.
- We received mixed feedback from doctors around training and professional development. Some doctors told us support and training had improved since the last inspection. We were told there were weekly training sessions and doctors received support to conduct audits. However, a number of locums told us they do not get good access to training and felt like they were not a priority. We were told since the trainees had left a couple of months ago access to training had stopped.
- One locum told us they were not up to date with advanced life support training (ALS). The department often relied heavily on locums each day and these staff could be potentially looking after patients who are in cardiac areas therefore ALS is important.

Multidisciplinary working

- We observed good MDT working and positive interactions across all staff levels and close working with local GP in the UCC.
- A number of speciality teams were accessible by staff to provide liaison services, including psychiatric liaison teams and alcohol liaison service. The psychiatric liaison service was staffed by a psychiatrist and mental health nurses (RMN). The service was available 24 hours a day, seven days a week. We observed good joint working between the service and the ED. We spoke to a number of RMN during the inspection who told us there was good communication between themselves and the ED and good access to information. The team did training on the ED KIT days to education staff around mental health.
- We observed a number of handovers from the ambulance service to the ED staff. These were well-structured and ensured all the relevant clinical information about the patients was conveyed appropriately.
- The ED worked with the local police and had a named police officer who was invited to attend KIT days.
- Staff were able to describe the protocols to treat and transfer patients, such as referrals to general medicine or surgery. Protocols were in place for patients about to be discharged to ensure follow ups were arranged, letters were sent to GPs following discharge. The ED was working with local GP's in the area to educate them around when referrals to ED should be made. The hope was that this would prevent unnecessary visits to the ED department.
- There were good working relationships with the safeguarding team and community paediatric team.
- There were dedicated nursery nurses in the paediatric ED who were well integrated into the team. They worked closely with the ED and helped reduce anxiety in children, such as through the use of effective distraction techniques.
- The ED had weekly meetings with the radiology team which included training on interpreting X-rays.

- We observed the ED had good links with the nutritional team who visited the ED on a regular basis. The ED had an nutritional link nurse and was organising training on nasogastric (NG) feeding. NG feeding is where a thin tube is inserted through the nostril, down the oesophagus and into a patient's stomach to delivery key nutrients and medication
- Twice daily handovers were attended by the medical staff and the nurse in charge. Nurses were called over in turn from each bay area to handover their patients.

Seven-day services

- The ED service for adults and children were open 24 hours a day, seven days a week.
- Consultants provided cover 24 hours a day, seven days a week, either directly within the department or on call. During some night shifts consultants were present in the department and staff spoke very positively about this.
- There was a 24 hour radiology service within the department which included the provision of X-ray. Computerised tomography (CT) and MRI scanning services were located in a different area but were available 24 hours when required.
- We were told pharmacy was not a 24 hour service and a pharmacist was only usually present in the department to around 6pm. Following this staff had access to an emergency drug store and an on-call pharmacist at night.

Access to information

- An electronic system to track patients in the ED was used throughout the department. Staff throughout the department including receptionists, nursing and medical staff had readily available access to IT terminals throughout the department. This enabled them to access patient records and the trust intranet for policies and guidelines. Agency staff did not have access to this system and therefore could not access patient notes.
- Alongside this there were paper notes of a patients episode of care readily available to staff.
- Each area in the department had an information board which gave details as to what the service did. For example, the 'majors lites' board described the purpose of majors lites and what patients should expect in this area.
- Information for patients visiting the department was readily available and was up to date. Current waiting times were displayed in the main reception.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures or tests that were undertaken by the staff. This included both written and verbal consent.
  - 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.
- ED staff we spoke with had mixed knowledge of the principles of consent and mental capacity, including the treatment of patients with Deprivation of Liberty Safeguards (DoLS) orders.
- Some staff were able to give examples of when patients might lack capacity to make decisions themselves, such as an unconscious patient. Staff told us they would make decisions which were considered to be in the best interest of the patient. However, some staff did not know what 'lacking capacity' meant, one staff member told us: "I have never heard of it".

Are urgent and emergency services caring?

Requires improvement 

We rated caring as requires improvement because:

- We observed some negative interactions including one staff member being frustrated with a patient who needed to use the toilet.
- We also observed a patient calling out for help and was ignored until we escalated to the nurse in charge.
- We observed one patient who was asking for help as the nursing station being ignored by a doctor.
- In the Friends and Family Test (FFT) the trust scored between 71% and 88% of patients recommending the department to others. This was below the England average.

However:

- Some patients we spoke with were positive about the care they received and we observed courteous interactions between staff and patients.

- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Staff provided emotional support to patients and relatives and could signpost them to other support services if required.

Compassionate care

- Positive interactions were not always demonstrated in the emergency (ED) department. For instance, we observed a patient ask a nurse if they could go to the toilet and the nurse responded in an unfriendly manner.
- We also observed a confused patient asking a doctor for help at the nurses station, who was responded to in an unfriendly and dismissive manner. The patient continued to ask for help and was ignored until a nurse came to help.
- We observed one patient shouting out for help numerous times and was ignored. We raised this with the nurse in charge who then attended to the patient.
- One patient told us they had asked for pain medication numerous times and was ignored. This had led to them feeling distressed.
- We saw that some staff demonstrated empathy and compassion towards patients. We observed nurses welcoming patients into the initial assessment area in a warm and welcoming way.
- We saw the a number of staff were caring and courteous towards patients during one to one interactions. Staff were approachable and friendly but always remained professional.
- Most of the patients we spoke with were positive about the care and treatment they had received. Patients said things like: “I feel well looked after”, “Staff are nice here they answer my questions”, “No problem here staff are on the ball”.
- In the paediatric department feedback from patients and relatives was very positive. They said things like: “I am very impressed, we were seen quickly”, “It’s very clean and people are always polite”, “I am glad I came here”, “Absolutely amazing, they are very fast and responsive”.
- General observations confirmed staff respected the privacy and dignity of patients. We observed curtains being drawn around cubicles and blankets being offered to cover patient if required.
- We observed that patients who arrived by ambulance and were waiting to be assessed in the Rapid Assessment and Treatment area were queuing in the corridors in trolleys and wheelchairs.
- Patients and visitors had contributed to the national Friends and Family Test (FFT), the results of which were below the England average. The trust scored between 71% and 88% of patients recommending the department on a monthly basis.
- The trust scored worse than other trusts in 13 out of 24 indicators relating to caring in the A&E survey (2014).

Understanding and involvement of patients and those close to them

- We saw nurses and doctors introducing themselves to patients and relatives at all times. Staff were observed to involve patients in their care and treatment and tailored their help to meet individual needs.
- Patients fed back that staff talked to them at an appropriate level of understanding and valued that staff listened to their views. One parent told us staff had ensured they explained things in a language that their child could understand.
- Staff ensured patients were fully informed before completing any intervention. In the paediatric department nursery nurses were available to use distraction techniques when carrying out painful procedures on children, for example taking blood.
- The ED had a ‘you said, we did; board which gave feedback on changes that were being made as a result of patient and relative feedback. For example, after feedback regarding poor communication the service was educating staff during staff meetings of the importance of ensuring good communication with patients.
- We observed staff told patients the general timeframe for being assessed, admitted or discharged. Patients told us they were kept informed of the treatment plans

and staff explained any test they were due to have. However, whilst the service was busy one patient told us "staff are too busy to keep me updated on my situation here".

Emotional support

- Feedback from patients and relatives was positive and they told us staff were supportive and had been reassuring. Staff demonstrated an understanding of patients and relatives' situation and worked well to lower patients' anxiety.
- The majority of the time staff took time to understand the needs of the patients to enable them to best address their concerns.
- The paediatric department nursery nurses were available to reduce anxiety in children, such as through the use of effective distraction techniques.
- However, one patient told us "I am really anxious and they haven't explained anything to me". We also observed an elderly patient calling out in distress and staff did not respond until we raised this with the nurse in charge.

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

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- The main waiting area and paediatric waiting area were very busy during our second unannounced inspection, and some patients were unable to sit down.
- Staff were unable to identify who the lead for dementia was and how to access support.
- The percentage of patients being seen and treated within the recommended four hour timeframe and number of patients who left the department without being seen was worse than the national average.

However:

- The department worked closely with local GPs to ensure they were meeting the needs of the local population. A joint information booklet for parents had been developed to educate them around treatment for common childhood illnesses and injuries.
- There were a number of specialist teams available to the department such as a frail and older people team, psychiatric support, domestic violence team, and alcohol liaison services.

Service planning and delivery to meet the needs of local people

- There were established links with social care providers and local clinical commissioning groups (CCG). The paediatric department had worked with the local GPs in developing an information booklet for parents giving information around self-help. The purpose of this was to prevent parents bringing their children to the ED when it could be dealt with at home or by the local GP.
- The department had plans to go-live on a child protection information sharing system by the end of October 2016. This was a national safeguarding database, which would help ensure better information sharing with the three local boroughs. Two of the local boroughs were already on the system and the trust were waiting for the final borough to go-live before going live themselves.
- ED staff were familiar with some information regarding the demographics of the people that used the service. The Borough of Havering had an age profile which was older than the London average, and staff reiterated this during the inspection. The department had access to a Frail and Older Persons Liaison Service (FOPAL), which regularly checked all patients 75 and above in the department. The service did assessments on vulnerability using a frailty score and liaised with social services, family and local community services. FOPAL initiated the Gold Standard framework assessment for patients who were through to benefit from the palliative care pathway. We saw one example of this and noted there had been discussion with the relatives.

- A number of other specialist teams were accessible by staff to provide liaison services. This included mental health liaison, alcohol and domestic violence services.
- The department had an escalation plan that described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances, which would create significant demand on the service.
- During the inspection we saw the clinical site manager was present in the department to discuss flow with the nurse in charge. This ensured the service was meeting the needs of patients. If required, doctors and nurses could be moved round the department to where it was most busy.
- There were no play specialists dedicated to the paediatric emergency department.

Meeting people's individual needs

- Patients being assessed or treated were offered drinks and snacks during 'comfort rounds'.
- The 'majors lite' area was used for patients with moderate illnesses and injuries and who were unlikely to need to be admitted to the main hospital.
- The children's waiting area was colourful and separate from the main reception. There were a number of age appropriate games and toys available for use, for example colouring sheets and crayons.
- There were leaflets available around the department about a number of health conditions, such as head injuries and back injuries.
- Each area within the department had an information board, which described the departments role and what uniform each type of member of staff wore.
- There was an information board called 'its good to talk' which gave details about access to interpreters. It also provided information about how to access specific communication needs such as for those with hearing loss or visual impairments.
- A multi-faith space was available to provide support within the hospital. There was information for patients informing them how to access the multi-faith space if required.
- Staff told us they could access interpreters for patients whose first language was not English. We were also told a number of staff could speak other languages and could be utilised if needed.
- Staff could sign post patients to an Independent Domestic Violence Advocate (IDVA) on site if there were any concerns about domestic violence.
- There was a lead nurse for people living with learning disabilities and staff said this was a huge support for them. The lead nurse had done some training sessions around suggested means of communication. There was also a learning disability pack available for staff, which included some basis sign language that could be used with those with communication problems.
- We found patients' needs and religious beliefs were taken into account. For example, patients were given choices of food including vegetarian and halal options and choices of male or female staff where practicable.
- The department had the butterfly scheme in place, which provides a system of hospital care for people living with dementia. Patients with dementia would have a purple butterfly on their records to indicate they suffered from dementia. However, we were told during the inspection staff were unaware who the dementia lead was within the department.
- It was not always possible to maintain patient confidentiality at all times. The children's waiting area was small and a number of seats were situated right next to the reception desk. Also, patient cubicles were separated by curtains and it was possible to overhear sensitive information or confidential conversations from the adjacent cubicle.
- During the second unannounced inspection we noted the waiting areas were very full and there were few chairs available for patients. Within the paediatric waiting area we saw a number of parents standing with their children due to a lack of seating space.

Access and flow

- Queen's Hospital March 2015 inspection report highlighted that in the past there been long waiting times for the majority of patients who attended A&E. The service had introduced 'streaming' which was a process designed to fast track patients to the right

places from reception, such as UCC, GPs or majors. The purpose of this was to prevent people waiting in the ED when it might not be required. Triaging was done following streaming.

- National indicators set by the government state that 95% of patients should be admitted or discharged within four hours. The percentage of patients seen within 4 hours had deteriorated over time and since August 2015 was rarely meeting the national indicator. Trust data showed between September 2015 and September 2016 this varied between 70% and 95% compliance.
- We saw failure to comply with the four hour indicator was rated as 'extreme' and was added to the departments risk register in May 2016.
- The percentage of patients who left without being seen was consistently worse than the England average of 2.7%. Between June 2015 and September 2016 there were 208,282 attendances and of these 11,919 (5.7%) left the department without being seen.
- The department was trying to minimise overcrowding by using 'redirect', in which patients were referred to other services such as pharmacy or UCC. The aim was to reduce the number of patients being admitted to the ED. Feedback from senior leaders was that the trial of this had gone very well.
- We found the rapid assessment and treatment process was not always as efficient as it was meant to be. During both unannounced inspections we saw ambulance crews queuing to handover their patients. Feedback from the ambulance crews was that generally they waited for less than 30 minutes to handover.
- The number of patients waiting between four and 12 hours to be admitted to a hospital from the ED was consistently lower than the England average. Between May 2015 and May 2016 there were 1,314 patients waiting four to 12 hours and three patients waited over 12 hours from decision to admit to hospital.
- The ED was meeting the 60-minute time to treatment national indicator for 42% of patients.
- The total time in ED (average per patient) for the trust was consistently worse than the England average. Between May 2015 and April 2016 the trust medium time in minutes was between 160 and 210 minutes, compared to a national average of between 130 and just below 160 minutes.
- We spoke with three members of the London ambulance service during the inspection. They all told us the waits in the ED were not that long compared to other hospitals. They told us staff in the hospital were very approachable and professional.

Learning from complaints and concerns

- There was a culture of openness around complaints in the department. Patient information on how to make a complaint or raise a concern with Patient Advice and Liaison Service (PALS) was available throughout the department.
- Senior leaders told us they tried to resolved complaints at a service level before progressing to a formal complaint with the trust. As per the previous inspection complaints were handled in line with the trust policy. If a patient or relative wanted to make a formal complaint they were directed to the nurse in charge of the department. The nurse in charge wore an arm band to make them easily identifiable. If concerns were not able to be resolved at a local level, patients and relatives were referred to the PALS, which would formally log the complaint and attempt to resolve the issue.
- Staff told us complaints were discussed during handover and every month during KIT days.
- Senior leaders told us at the time of the previous inspection there was a backlog of complaint investigations. We were told this backlog had now been cleared.

Are urgent and emergency services well-led?

Requires improvement

We rated well led as requires improvement because:

- Since the previous inspection we found there were improvements. However, we identified a number of things that needed to be more embedded.

Urgent and emergency services

- There was no clear vision and strategy for the service as we were told plans for the department were constantly changing. Some staff did not know about the departments plans to close King Georges accident and emergency department at night.
- Levels of resuscitation training for all staff were low and we had concerns the department did not monitor the resuscitation training of their locum medical staff appropriately.
- There was no divisional nurse lead at the time of our inspection as this post was out for recruitment.
- We found no evidence of action plans to improve poor compliance with hand hygiene and infection prevention and control practices. However was told an link nurse was being allocated.

However:

- Leadership was visible and directly involved in clinical activity. Staff were positive about changes in the department and were starting to feel more optimistic.
- The service had improved clinical governance structures and risk management since the past inspection in March 2015. An external organisation had worked with the trust on ensuring their governance structures were more robust.The trust had rebranded clinical governance as 'quality and safety' and meetings took place on a monthly basis.
- The departments understanding of risks and issues generally corresponded with those described by the majority of staff. Improving risk management was clearly a priority for the department and the register was more robust than previously.

Leadership of service

- Leadership and management of the department was shared between the two clinical leads and the matrons. 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 were positive about the executive team and the positive changes they had made to the service over the past 12 months. We were told there were regular walk arounds in the department.
- All staff we spoke with told us they were happy with the management and leadership of the service. There were clear lines of accountability in place and staff were aware of who they could go to for help or to escalate a problem.
- Staff told us they felt the biggest risk to the service was staffing levels and managers were aware of this. Staff were given regular updates about recruitment during staff meetings. The service had over recruited on band 5 nurses in order to make up for the band 6 vacancies, and were supporting band 5 staff to act up into band 6 roles.
- Managers were keen to reward staff for their good work and had introduced the 'terrific ticket'. This was a voucher given to staff for them to 'have a drink on us'.
- Junior doctors we spoke with told us that they were happy with the support they received from consultants, however they felt sometimes the workload was quite high.

Vision and strategy for this service

- Staff told us the trust values of Passion, Responsibility, Innovation, Drive and Empowerment (PRIDE) were discussed during the trust induction and were embedded in their practice.
- At the time of the inspection senior leaders told us the clinical strategy was currently being written. We were told they want to continue to make improvements to the department and make it feel more energised, with improved morale. The executive team were aware of a five year plan for the emergency department, however we were told plans were constantly changing.
- One of the main strategies was around the transformation of urgent care at BHRUT. The plan was for the UCC and majors lite to become one service in the future, however the trust have not decided what this will be called yet. The UCC at Queens Hospital is currently open 8am till midnight although the GP's finish at 10pm. The proposal is for the new UCC to provide cover twenty four hours a day, seven days a week.

- Senior leaders told us there were plans for King George A&E to be closed during the night. However, the majority of staff we spoke with did not know about this.
- Senior leaders told us they had recently had an away day to discuss the plans for the ED in the future.

Governance, risk management and quality measurement

- Department leaders told us in the past systems of clinical governance were not robust. The trust brought in external organisations to help set up systems and processes for governance. There was a substantial drive in the department to improve quality of the service through robust and consistent clinical governance practices.
- The ED had monthly safety and quality meetings and monthly unit meetings which was used to ensure learning from incidents and complaints were embedded into the practice. We noted from minutes of these meetings that complaints, incidents and emerging risks were discussed, evaluated and monitored. We saw Information from these meetings was fed back down to staff during the daily staffing briefings in the morning. For example, during our second unannounced visit a new serious incident was being investigated and staff had been given updates about this.
- Structures to maintain risk management existed and divisional leaders understood these systems within the department. Senior clinicians met regularly with management to discuss risk management. We looked at the risk register for the division. Each risk had a red (extreme), orange (high), yellow (moderate) or green (low) risk rating. Each risk was allocated a responsible person and there were detailed actions of what the department was doing to mitigate risk, including progress. However, we noted in the June 2016 safety and quality meeting minutes it was highlighted that "more work needed to be done to prove to the trust that the division is in control of its risks". It highlighted there was still room for improvement.
- There was some misalignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'. For example, nursing staffing levels was raised consistently by staff but this was not on the divisions risk register. However, we noted in some of the safety and quality minutes from April 2016 that "workforce vacancy impacting on patient safety – nursing" was recorded as an amber risk. However, we could not find this on the risk register provided by the trust.
- 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. The department used a high number of locum medical staff, and were unable to provide us with assurance that staff had appropriate resuscitation training as this was not something they monitored themselves.
- Senior leaders were aware of the issue around nursing vacancies, particularly the high band 6 vacancy rate. The department had over-recruited band 5 nurses to compensate for the lack of band 6 nurses, and management of the department supported band 5 staff to act up into band 6 roles through in-house training, individualised action plans and development opportunities. Band 5 nurses acting up were provided with regular supervision from the band 7 team leader.
- Senior leaders told us an infection prevention and control (IPC) nurse was being allocated to improve compliance with hand hygiene and IPC. However, this was not in place at the time of the inspection.
- The trust had appointed a sepsis lead to oversee the department sepsis management. The trust had implemented a sepsis steering group who met on a regular basis. This had resulted in the introduction of sepsis trolleys into the department and an educational programme around sepsis to raise staff awareness.

Culture within the service

- All of the staff we spoke with talked openly about the culture within the service. A number of staff told us they felt more positive over the past 12 months and that morale was improving.
- Nursing staff told us they were well supported by the senior matrons. There was an open door culture encouraged in the department and staff told us they would feel comfortable raising any issues with the matrons.

Urgent and emergency services

- We observed staff work together to complete tasks and ensure suitable patient care took place. Nurses and doctors demonstrated good working relationships and nurses told us they felt comfortable challenging doctors.
- Staff understood the importance of being open and honest when things went wrong. All staff we spoke with knew with understood principles relating to duty of candour.
- All staff we spoke with were passionate about providing empathetic care.
- Some medical staff we spoke with said they would not recommend working in the department to others, due to lack of access to training.

Public and staff engagement

- There was a lot of information around the department informing patients and relatives how they could give feedback. Including patient surveys, Patient Advice and Liaison Service (PALS), comment cards, NHS choices and nominating staff for 'star of the month'.
- There were large signs around the department asking patients to complete the Friends and Family Test (FFT).
- There was a 'you said, we did' board in the main waiting area which gave feedback regarding the most common concerns raised. The trust gave information about what they was doing about these concerns, such as staff training around communication.
- The ED had its own twitter feed which was used to give the public feedback around what was going on in the department. This included regular postings of the department's newsletters. Newsletters gave information about training, incidents and complaints within the department.
- The twitter feed also posted information about which staff had won 'star of the month' and who had received 'terrific tickets'.
- Similar to the last inspection we were told there were no formal debriefs following disturbing incidents and no time for structured debriefing sessions. However, senior leaders told us staff were offered one to one time if required.
- Senior leaders told us they had spoken with staff regarding changes to the ED department at King George Hospital. Some staff we spoke with were aware of a potential new urgent care centre model, however a number of staff were unaware of any potential changes to the department.

Innovation, improvement and sustainability

- The service was aiming to fill in the gaps of the medical staff vacancies and address recruitment problems. The plan was to train nurses to be advanced practitioners who will work in a six bedded area to carry out initial assessments of patients on arrival. Patients will then be signposted on to specialist areas or redirected to other areas of primary care. This model would give staff maximum opportunity to develop and progress.
- The ED had developed a structured framework to facilitate research within BHRUT at Queens. This would enable trainees to do research with the support of an in-house research group.
- An emergency medicine trainee platform had been developed in order to improve education at Queens. The plan was to have one to one with consultants, workplace experiential learning, simulation training on a fortnightly basis, post graduate formal teaching and self-directed learning
- The service had developed an advice booklet for parents with local Clinical Governance Groups (CGC's). The booklet gave information around a number of different diagnosis and what steps the parents could take for treatment. The aim was to educate parents so they knew when treatment required a visit to the ED and when it did not. This helped prevent unnecessary trips to the ED.

Medical care (including older people's care)

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

Information about the service

Within Queen's hospital, both the medical care and care of the elderly services are managed divisionally under acute medicine and specialist medicine. This division includes the specialities of acute assessment, respiratory medicine, renal medicine, cardiology, gastroenterology, diabetes and endocrine care, and hepatology[HD1]. The wards we visited were the coronary care unit (CCU), diabetes and endocrinology, elders receiving unit (ERU), stroke, renal, oncology and haematology, medical assessment unit (MRU), neurosciences and hyper acute stroke unit and elderly care wards.

Between September 2015 and August 2016, there were 57,299 admissions to the medical service at Queen's hospital. Of these admissions, 64.81% were emergency admissions, 2.79% were elective and 32.41% were day case patients. There were approximately 429 inpatient beds and 28 day case beds within the medical division at the hospital.

We visited Queen's hospital as part of our unannounced inspection on 7 September 2016 and again as part of a follow-up unannounced visit on 16 September 2016. During the course of this inspection, we visited 12 of the medical wards. We spoke with 37 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 also 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:

- Infection prevention and control audits, as well as hand hygiene audit results, showed consistently poor compliance in some wards and departments, such as Bluebell B and Clementine B.
- Although most medication was monitored and stored appropriately, we found a pack of pH indicator strips and an anaesthetic cream on two wards which had expired.
- 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, 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.
- 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 standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were inappropriate.
- For non-elective admissions, the standardised relative risk of readmission was also higher, particularly for clinical oncology.
- 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.
- 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. 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 pathology service was understaffed and unable to provide effective cover out-of-hours.
- The trust performed slightly below the national average in the National Cancer Experience Survey 2015.
- 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 slightly from the previous year. One ward in particular, Mandarin A, experienced a high number of bed moves occurring out of hours (between 10pm and 6am) in the months July and August 2016. 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.
- 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.

Medical care (including older people's care)

- The risk register highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards.
- Patient information leaflets were not standardly available in languages other than English.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
- The NHS staff survey results were variable, with the trust still scoring below the national average in many measures.

However:

- There had been improvement in the reporting of incidents and the sharing of lessons from these across the hospital.
- Staff we spoke with 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.
- 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 drive improvement. Staff told us that these led to meaningful change across the service.
- Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for thirteen indicators out of twenty-one indicators.
- The High Acute Stroke Unit (HASU) saw a steady performance in the Sentinel Stroke National Audit Programme (SSNAP) from April 15 – December 15 with SSNAP level remaining at performance level 'B'across all quarters.
- 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.
- Multidisciplinary team working was effective. Most staff said they were supported effectively and felt valued and respected.
- The majority of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- 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).
- All wards had a performance noticeboard on display which showed the most recent FFT scores.
- Patients' privacy and dignity was maintained throughout their hospital stay.

Medical care (including older people's care)

- 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.
- 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.
- The average length of stay for all elective and all non-elective patients was below the England average.
- 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.
- Catering menus offered many options to cater for those with different nutritional requirements.
- Posters for communicating with patients with a hearing impairment were displayed on notice boards and deaf awareness training was also offered to staff on all wards.
- 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, however this is still being embedded in some areas.
- 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.

Medical care (including older people's care)

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, such as Bluebell B and Clementine B.
- Although most medication was monitored and stored appropriately, we found a pack of pH indicator strips and an anaesthetic cream on two wards which had expired.
- 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, 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.

However:

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

- 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, there were 53 serious incidents reported at Queen's Hospital. Grade 3 pressure ulcers were the most commonly reported type of serious incident (24), followed by slips, trips and falls (7) and treatment failures and delays (7). Bluebell A (the medical and respiratory ward) reported the most incidents relating to hospital acquired pressure ulcers in this period. Sunrise A (an elderly care ward) reported only one incident in the same period. The majority of incidents caused moderate or short-term harm to patients but 14 incidents resulted in severe or permanent harm.
- All staff that we spoke with were aware of how to report incidents using the electronic trust wide incident reporting system. Staff were encouraged to report incidents and felt supported by their line managers when they did. Staff told us they received feedback from incidents reported across the trust in the form of lessons and action plans shared with them via email and in safety huddles, senior sisters' meetings and handovers. The reporting system had been revised to ensure mandatory feedback as the incident investigation could not be closed until learning had been extracted.
- On Mandarin Ward A, a junior doctor told us of a serious incident that occurred within the last 12 months when a patient who was bed bound was not cared for appropriately over the weekend. As a result,

they developed pressure ulcers. The investigation into this incident led to an 11am bell being introduced to the ward to remind staff that patients needed to be repositioned. Staff were reminded of the importance of doing this regularly.

- On Sunrise Ward B, we spoke with a senior sister who had completed a root cause analysis (RCA) for a patient who developed a serious pressure ulcer whilst an inpatient. The investigation found the cause to be an incorrectly used dressing and poor documentation. Staff were asked attend tissue viability training sessions, as well as refresher training on using the correct documentation.
- Staff of all grades, including those who had not previously completed a serious incident form, confirmed that were familiar with learning resulting from serious incident investigations.
- The ward manager of the elderly receiving unit (ERU) described a serious incident relating to a fracture that occurred January 2016. Learning from this serious incident was discussed with the team in daily ' safety huddles'.No serious incidents relating to fractures had occurred on the ward since this time.
- 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.
- Staff at all levels demonstrated a good understanding of what the duty of candour meant to them as clinicians. 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. It was clear that duty of candour was embedded in the culture of the hospital. Staff understood they were required to be honest and open about things that went wrong. They were aware of their responsibility to inform patients and their relatives when this happened and provide them with an apology. A doctor gave us an example of when he apologised to a patient and their relative because of a cream that should have been prescribed but had not been.
- The matron of the coronary care unit (CCU) was involved with investigations and writing letters to patients where duty of candour requirements were met. We were also shown a letter of apology that had been sent to a patient from a ward manager on Mandarin Ward A.
- We observed that duty of candour was discussed in clinical governance meetings. However, the staff in the trust did not undertake training specific to the duty of candour.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. We saw 'quality of care' boards on each ward that we visited. Each displayed the ward's monthly quality data and indicated how many days had passed since an incident causing harm had occurred. On the ERU, the board showed there had been no falls (222 days since the last fall that had led to harm), no pressure ulcers (42 days since the last pressure ulcer), and no medication omissions in September 2016. Since the ERU had opened, there had been no cases of hospital acquired Clostridium difficile (C. diff) or Methicillin-resistant Staphylococcus aureus (MRSA) since 9 February 2015.
- 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.
- Patients were routinely assessed for risk of pressure ulcers, venous thromboembolism (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.

- 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.

Cleanliness, infection control and hygiene

- The equipment and environment we checked was visibly clean. Most equipment had green stickers to show they had been cleaned in the last 24 hours. We observed cleaning taking place whilst on the wards.
- There was sufficient access to handwashing and drying facilities. Patients stated that they saw staff washing hands and using personal protective equipment (PPE) on when necessary, though we observed on the medical receiving unit (MRU) that not all staff were washing their hands in between seeing patients.
- We observed staff on all wards conforming to the bare below the elbow policy with access to PPE if needed.
- We observed there to be isolation rooms on most of the wards we visited. A patient on Harvest Ward B who was a C. diff carrier, was appropriately nursed in an isolation room, with clearly documented signs on the door evidencing this.
- Staff knew who the trust lead for infection prevention and control (IPC) was. Nursing staff told us that IPC link nurses visited wards regularly and undertook audits, with the results then being fed back to staff on the wards. Results from a trust wide IPC audit that was undertaken between May 2016 and July 2016 showed good results across the majority of wards. Further work needed to be done to improve the compliance rate amongst wards such as Bluebell B and Sky A. Hand hygiene audits showed good result for most wards in August 2016 such as MRU (100%), Sunrise B (98%), Clementine A (98%) and Harvest Ward B (96%). However, some wards performed significantly worse, Bluebell B (31%) and Clementine B (65%).
- Clinical and non-clinical waste was segregated appropriately. Sharps bins were appropriately placed, dated and not overfull.
- However, on the renal ward, we observed a patient in an isolation room who we had been told had CPE infection (carbapenemase-producing Enterobacteriaceae). Enterobacteriaceae are a family of bacteria, many of which live naturally in the bowels. These bacteria produce carbapenemase enzymes that can break down many types of antibiotics, making the bacteria very resistant. We noticed that the door to the isolation room was wide open, even though the policy states that the door should be closed. We informed a member of staff who closed the door. We then observed another member of staff entering the room without appropriate PPE. When they exited, the door was left open again.
- We saw 'cleaning matters' boards on wards which gave information detailing what patients could expect to see cleaned every day and encouraged patients to tell staff if something needed to be cleaned. .

Environment and equipment

- The trust's 'medical equipment maintenance status dashboard' reported that 44 units of equipment across the wards at Queen's hospital were missing or needing repair. Staff generally felt that accessing equipment was easy and straightforward. However, nursing staff on Harvest Ward B told us that it could sometimes be difficult to access electrocardiogram (ECG) machines. One member of staff had recently visited three wards in pursuit of an ECG machine.
- Ward staff told us that if there was equipment that needed to be replaced, then they could contact the bed and site management team.
- A matron on one ward told us that previously there had not been enough computers. However, there were now computers for ward clerks, nursing, pharmacy and medical staff, with two portable computers available to doctors.
- We saw resuscitation equipment accessible in all clinical areas we visited, with tamper-proof seals on them all. We saw evidence that nurses had completed daily checking processes to ensure they were ready for use at any time. On the MRU, we were told that if a

resuscitation trolley had not been checked, a letter would be sent out to the member of staff responsible and the matron would be notified. We observed sufficient checklists available within the resuscitation folders.

- Disposable equipment was easily available, in date and appropriately stored. The service had recently invested in computerised automated dispensing cabinets, which monitored supply levels and automatically placed orders when stock was low. The system used PIN and fingerprint recognition to identify which staff used which products. Staff reported this new system to be a lot better than the previous system, making it easier to find items. However, this was not yet live across all wards.

Medicines

- We checked a sample combination of over four hundred medications, including controlled drugs (CDs) and intravenous liquids. They were all in date and stored appropriately in controlled access treatment rooms, within locked cupboards and cabinets. Compliance with the CD policy was evident. There were processes for undertaking routine counts of stock, with signatures to support such checks.. The nurse in charge held keys to the treatment rooms and controlled drugs cupboards.
- Medicines requiring cool storage were stored appropriately in locked refrigerators and daily records showed that they were kept at the correct temperature. Where temperatures were not within the required range, this would be recorded in the log book with appropriate actions taken to remedy this. On the MRU, we found an anaesthetic creamthat had expired in the month prior to our inspection. We raised this with the nurse who removed it from the fridge and reported it to the pharmacist.
- On the ERU, we also found a pack of pH indicator strips which had expired.
- Pharmacists visited wards regularly to review stock medication levels and to carry out medicine reconciliation. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up-to-date prescriptions are used. We observed pharmacy staff checking take away medications before they were given to patients. 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. [Kk1]
- We reviewed twenty Medicine Management Records (MARs charts), most of which were up to date with few very prescription errors or missed doses. Drug histories, known allergies and pharmacy interventions were all recorded. However, on the CCU, a dose of furosemide (a water pill that prevents the body from absorbing too much salt) had not been given to a patient and another patient had not received their eye drops as prescribed. We observed two nurses present whilst undertaking a drug round. A portable lockable trolley was used and nurses provided explanations to the patients about the drugs they were being given. Nurses checked for allergies and did not leave the medications unattended at any time.
- A monthly audit of omitted doses indicated improvement across the trust within the last year, with 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.
- 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 trust 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.
- We saw 'Record Keeping Standards' posters located across the wards, reminding staff to record inpatient documentation legibly, accurately and comprehensively.
- Patient's medical records were kept securely in lockable trolleys, ensuring patient confidentiality was maintained.
- On the MRU, the matron told us that a recent initiative had been introduced where nurses on the ward would scrutinise each other's nursing folders and patients' charts to ensure that documentation was being completed appropriately. This professional challenge meant that any omissions or errors recorded in patients records would be picked up and learnt from.
- We looked at twenty sets of patients' records and found that all nursing records, including food and fluid charts, observation charts, National Early Warning Scores (NEWS) and drug charts and were fully completed and up-to-date. Cognitive assessments were completed for patients where necessary. In the CCU, an additional document called 'pathway for circulation – advanced management' had been completed in patient's records.
- Nursing and doctors' notes were generally legible and detailed. We found that records had names and designations of doctors.

Safeguarding

- We found there to be effective safeguarding policies and procedures, which were understood and implemented by staff. Staff were able to tell us the process for reporting safeguarding concerns and knew where they would access the safeguarding policy and procedures. However, on Harvest B ward, we saw a printed safeguarding policy that was out of date. The updated policy was still available on the intranet.
- Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse and how to raise an alert. One member of staff gave an example of when she raised a safeguarding alert because a patient had acquired pressure sores in the hospital.
- Safeguarding formed part of the statutory training programme at the trust. 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.
- Most staff that we spoke with knew who the safeguarding lead was. There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes were shared.

Mandatory training

- Most training was delivered via e-learning modules but the education department also ran classroom based teaching sessions. Courses were advertised on the intranet, and through emails and monthly staff newsletters. It was the responsibility of each staff member to ensure they had completed their training but their line managers were to ensure that staff were competent.
- There had been significant improvements in compliance across most training courses with average compliance at more than 90% for nursing across both the acute medicine and specialist medicine divisions:

fire safety training (93%) and (96%) respectively, conflict resolution (93%) and sepsis training (98%) across both divisions against a trust target of 90%. However, there had been a decrease in compliance for Advanced Resuscitation Adult Level 3 across the acute medicine division due to lack of availability of courses, compliance rates for nursing staff in this division were 55%. A resuscitation recovery plan had been developed in response, which included: bespoke sessions for planned cohorts of staff, utilisation of e-learning/practical assessment methodology and forward planning to book members of staff on courses who were about to become non-compliant.

- Training rates amongst medical staff in mandatory and statutory training was generally below the compliance rate of 90%. In Basic Life Support – Resuscitation Level 2, both medical staff in the two divisions were (80% in acute medicine) and (82% in specialist medicine). For Conflict Resolution, compliance rates amongst medical staff were (75% in acute medicine) and (82% in specialist medicine). However, medical staff in the specialist medicines division achieved a rate of 91% in (Adult) Sepsis training.
- Long-term locums were included in mandatory training plans to ensure local requirements were met, such as achieving trust targets and to ensure the potential risk of harm to patients was minimised.

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.
- The hospital used a national early warning score (NEWS) system to identify when patients were deteriorating using variations in different observations such as heart rate, blood pressure and oxygen levels.
- The NEWS audits we reviewed for August and September 2016 showed compliance with completing the necessary observations. Patient records we reviewed showed patient observations were completed. Where appropriate, these were escalated and patients received medical interventions in a timely way.
- 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.
- Magnetic symbols were used on patient information boards to identify those patients who were at risk of falls, those needing regular comfort rounds, those with nutritional or communication needs, and those who had a diagnosis of dementia or delirium.
- Across the wards, we saw that VTE assessments had been completed in a timely manner for 20 patients' records we looked at.

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, with the ratio of nursing staff to patients averaging 1:7 or 1:8, in line with national institute foe health and care excellence (NICE) guidelines. The Trust used the Safer Nursing Care Tool (SNCT) as an indicator for safe staffing levels across relevant ward areas within the trust.
- Whilst improvements had been made in staffing levels since the last inspection, there were still some vacancies across a number of wards. This meant some wards were operating without the required number of staff. On Sunrise Ward B, managers informed us that two healthcare assistants (HCAs) had been recruited to vacant posts, but pre-employment checks were still ongoing. There were also vacancies for three registered nurses on the same ward. However, we

were told that interviews were scheduled that week for two of these vacancies. On Harvest Ward B, we spoke with a band 5 Nurse who told us that there were consistently vacant posts, but these were generally covered by regular bank staff. Figures showed that there was a staffing vacancy rate of 23.64% and that agency usage within stroke services fluctuated between 13.8% to 22.6% between March 2016 to August 2016.

- On Mandarin Ward A, managers informed us that one band 5 nurse was on maternity leave and one band 5 and one band 6 nurse were on long term sick. The use of bank and agency staff was variable but efforts were always made to ensure that regular bank and agency staff, who were familiar with the ward and patient speciality were used to fill shifts. Usage of bank and agency staff in the renal service was 19.0% in April 2016 and 31.6% in July 2016.
- We saw minutes from a business and planning meeting, which showed that action had been taken against two members of staff registered with bank who were banned from working in the trust due to poor clinical practice.
- A band 5 nurse on Harvest Ward B told us that the ratio of nursing staff to patients was previously 1:10, which is higher than the recommendation made by NICE. The band 5 nurse told us that this composition was difficult because of the complexity of the patients. However, adjustments had been made to bring staffing ratios in line with patient acuity. There were now four registered nurses (RNs) and three HCAs on each day shift and three RNs and three HCAs on each night shift, with the correct skill mix being assigned to patients.
- On the day of inspection, Clementine B ward was fully staffed. Overseas recruitment from the Philippines, Italy and Finland was underway to fill a number of vacant nursing roles.
- We saw that inadequate staffing levels on Bluebell Ward A had been highlighted as a concern on the risk register, resulting in continuity and quality of care being compromised. Plans to adjust the skill mix, recruiting to vacant posts and moving staff from other areas had been implemented to remedy the problem of staff shortages.
- The most recent data provided regarding sickness figures showed that in July 2016, the sickness rate for the service had exceeded the trust's target of 3.2%. However, the coronary care unit achieved a zero figure of sickness that month.
- The recruitment of eight Dementia HCAs had taken place across the trust and were due to start at the end of October to provide extra support and monitoring to acutely unwell patients who also had a diagnosis of dementia. This was deemed necessary due to their increased nursing needs.

Medical staffing

- Compared to other trusts, there was a greater reliance on junior doctors across both Queen's and King George's hospital. Medical staffing comprised 33% consultants (against a 37% national average), 9% middle grade 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 23.3% and 18.4% for the period of March 2016 to August 2016. In the same period, locum usage in care of the elderly services ranged between 17.7% 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.
- Safe patient care on Bluebell A, a medical and respiratory ward had been highlighted on the risk register, due to high levels of both medical and nursing staffing vacancies and turnover, as well as high numbers of junior staff in post. The respiratory service had a vacancy rate amongst medical staff of 25.62% and a medical staffing turnover rate of 80% between September 2015 and August 2016.
- The inability to provide adequate medical staffing on the diabetes and endocrinology ward had been highlighted on the risk register on 4 March 2016, which

was risk assessed as potentially increasing the length of stay and potential harm to patients. The turnover of career grade medical staff for the service had been 50% between October 2015 and September 2016.

- In the renal medicine service, nursing staff told us that medical staffing was good and that every day there was a consultant on shift. We were told that there was an on call team during the night comprising of one registrar, one senior house officer (SHO) and one on-call consultant.
- On Sunrise Ward B, an elderly care ward, nursing staff told us that there was always a consultant on the ward, with consultant led board rounds that took place at 9am and 2pm.

Major incident awareness and training

- Staff had awareness of what actions they would take in the event of a major incident, including a fire. Fire training was provided to staff, with overall compliance in this training. Drills were completed on induction and there was information available on the intranet about major incidents.

Are medical care services effective?

Good

We rated effective as 'good' because:

- 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 drive improvement. Staff told us that these led to meaningful change across the service.
- Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for thirteen indicators out of twenty-one indicators.
- The High Acute Stroke Unit (HASU) saw a steady performance in the Sentinel Stroke National Audit Programme (SSNAP) from April 15 – December 15 with SSNAP level remaining at performance level 'B'across all quarters.
- 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.
- Multidisciplinary team working was effective. Most staff said they were supported effectively and felt valued and respected.
- The majority of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

However:

- 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 standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were inappropriate.
- For non-elective admissions, the standardised relative risk of readmission was also higher, particularly for clinical oncology.
- 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 signifcantly in the 2016 survey, some issues still remained.

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

Evidence-based care and treatment

- 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.
- We saw examples of recent local audits that had been completed on the wards. One ward that we visited completed four mandatory audits of the safety thermometer, patient observations, documentation, and a falls/wristband audit. In the safety thermometer audit, the ERU was providing above 95% harm free care to patients in the months June 2016 to September 2016. However, in April 2016 the ward had achieved a score of 66.67% and this had been the result of a patient who had been admitted with a pressure ulcer that had been acquired in the community. In the patient observations audit which looked at recording physiological vital signs in patients, the ERU scored 100% in all five measures for the months July, September and October 2016. In the measure 'is the required frequency of observations clearly defined', the ward scored 80%, 80% and 90% for the months May, June and August 2016 respectively. [Kk1]In the wristband audit, results showed that of 70 patients audited between April 2016 and October 2016, all 70 patients had been issued with a wristband with identifiable information such as patients' first name and surname, date of birth, eight digit hospital number and NHS number.
- On the ERU ward, we were told that daily audits were introduced after the 25 July 2016 around tissue viability. This was due to three grade 3 and two deep tissue injuries that had occurred in the preceding six months. Senior staff told us that pressure area issues were not attributable to nursing care but arose from documentation issues. Patients receiving oxygen therapy had also been factored into the audits, as long-term oxygen therapy could lead to soreness of the ears and thus put patient's earlobes at risk.[Kk2] The matron told us that consistency of the audits had helped to improve patient outcomes and treatment in this area. The ward would continue with the audits until the ward were happy that pressure ulcer incidents were eliminated. We were told that root cause analysis (RCA) of the incidents, including action plans, were presented at meetings that other ward managers attended, so that learning was shared across the hospital.

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.
- Pain was well managed 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. Staff told us there were no delays in getting the pain team to review a patient. The pain team opening hours were Monday – Friday 8am – 8pm, Saturday 8am – 4pm and Sunday 10am – 1pm.
- Pain scores were recorded and we saw evidence of patients receiving pain relief in a timely manner. We saw examples in the records of pain control managed with PRN (pro re nata - medicines that are taken "as needed") pain relief.

Nutrition and hydration

- Across all of inpatient services, we saw patients were screened for risk of malnutrition on admission to

hospital using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST). High caloric diets and supplements were given to patients who were found to be undernourished or underweight.

- Most wards had protected meal times and patients generally had a choice in what they ate, such as meals that were gluten-free. Menu cards were filled out by staff for patients requiring a pureed diet or a healthy balanced diet for those patients who were diabetic. Protected mealtimes were in force from 12pm – 1pm. Protected mealtimes are
- Wards had appropriate systems in place to ensure that patients' food and fluid intake was recorded when required. We saw evidence that most care plans were regularly evaluated and revised as patients progressed through their care and treatment.
- Staff told us that referrals to dieticians could be made when necessary. The time taken from referral to a dietician seeing a patient was generally 24 hours. For those patients with a nasogastric tube (NG tube) or percutaneous endoscopic gastrostomy (PEG), which are medical devices used for patients who cannot obtain nutrition by the mouth, there was a devised feeding regime. Involvement from dieticians was always sought.
- A red tray system was used to alert staff that a patient needed assistance with eating. Red lids on water jugs were also used which alerted staff that patients needed assistance with drinking.

Patient outcomes

- At Queen's Hospital, the standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were inappropriate. However, other factors could be to blame, such as patients having other comorbidities (the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder) or poorly organised rehabilitation and support services when a patient is transferred home following treatment.
- For non-elective admissions, the standardised relative risk of readmission was also higher, particularly for clinical oncology. However, national research suggests that hospital readmissions for patients with a diagnosis of cancer are largely not preventable.
- In the National Heart Failure Audit (2013/14), the hospital performed equal to, or better than, the England average in five out of 11 measures. However, the results showed no improvement from the previous year when measured against the England average, as it performed equal to or better on the same five measures overall. Areas where the hospital performed significantly worse included: cardiology inpatient care (29% against an England average of 49%), input from consultant cardiologist (31% against an England average of 60%). Where the hospital performed fractionally worse included: prescriptions of angiotensin-converting enzyme inhibitors and receptor blockers on discharge (83% against an England Average of 85%) and beta blockers on discharge (82% against the England average of 85%). 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.
- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2015, Queen's hospital performed better than the England average in 13 out of the 21 audit measures. Significant improvements had been made in foot risk assessment since the previous audit. However, one of the measures where the hospital performed below the England average is where patients were not seen by the multidisciplinary foot team (MDFT) within 24 hours.
- 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. To improve results in indicators where the trust was falling below expected standards, an action plan was implemented. There were plans to undertake holistic needs assessments of all patients, complete treatment card summaries for all patients, not to just those having SACT (systemic anti-cancer therapy) and radiotherapy, and to achieve all cancer standards by increasing capacity for CT (computed tomography) guided biopsy, increase capacity for lung function test and to avoid delays in referrals sent to surgery.

- In a national audit of care of patients with non-ST segment elevation mycordial infarction (nSTEMI), a form of heart attack, as part of the Myocardial Ischaemia National Audit Project (MINAP, 2013/14), Queen's hospital performed slightly worse than the England average for a number of measures. For patients who were admitted to a cardiac unit or ward, the hospital scored 51.4%, against a national average of 55.6%. Again, the hospital performed slightly worse than the England average for patients who were seen by a cardiologist or member of the team (92% against 94.3%), and also slightly worse for patients who were referred for angiography (76.8% against 80.3%). The trust could not provide an action plan devised as a result of this audit.
- Queen's hospital High Acute Stroke Unit (HASU) saw a steady performance in the Sentinel Stroke National Audit Programme (SSNAP) from April 15 – December 15 with SSNAP level remaining at performance level 'B' (on an A-E rating scale, where A is the highest) across all quarters. However, January 16 – March 16 saw a decline in performance with SSNAP level dropping to level 'D'.
- The trust was participating in or due to participate in a number of national audits such as Inflammatory bowel disease programme (IBD) and the National Audit of Dementia.

Competent staff

- Appraisals were completed annually with six monthly reviews. Most staff that we spoke with told us that they had completed their appraisals for the year. Staff told us that appraisals were structured around the PRIDE hospital values. We saw evidence of this in the electronic system used. Appraisals data provided by the trust indicated that between 77.78% and 100% of staff had received appraisals between April 2015 and March 2016.
- Junior doctors generally felt that they were well supported by their consultants. They told us that consultants were contactable by telephone for help and advice when necessary. 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. In the 2016 survey, results had improved significantly but some issues still remained.
- Staff told us there was no element of formal supervision provided outside of the appraisal process. However, staff told us that in the event of a member of staff completing a drug error, they would have to complete a medicines management course and would have a mentor for 12 weeks.
- Some staff told us that previously it had been difficult to access continuing professional development (CPD) opportunities but the new electronic system made this easier and more accessible. However, staff would have to complete all statutory and mandatory training first.
- We were told that bank and agency staff on arrival to work on a ward would be given an induction and be given a tour of the ward. Staff provided us with templates of the trust's local induction checklist that were given to bank and agency staff. We were shown seven examples of an induction checklist that had been completed and signed by a new starter and countersigned by a ward manager.
- 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, due to extenuating circumstances.

- 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). We were provided 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.
- The trust ran a nurse preceptorship programme that included five study days over the course of 12 months. The programme was to support and guide a newly qualified member of staff and enable them to be confident and competent practitioners. These sessions covered topics such as communication, teamwork and effective delegation, medicines management, safe practice and personal and people development. Nursing staff had competency packs that were signed off once completed.[Kk9]

Multidisciplinary working

- Multidisciplinary team (MDT) working took place on the wards we visited which included stroke, elderly care, MRU, diabetes and endocrine wards. We were told that MDT working was generally good. However, a junior nurse but we spoke to on the CCU told us that the last cohort of junior doctors did not communicate with staff and were "quite arrogant". This had been addressed by the ward manager who spoke to the consultant.
- Each ward had a multidisciplinary team (MDT) meeting which included doctors, nurses, occupational therapists, physiotherapists and other allied health professionals (AHPs) as appropriate. Each patient was fully discussed, including treatment and discharge plans and this was fully documented.
- A ward manager on the ERU told us that there was good collaboration with palliative nurses, oncologist nurses, social workers, SALT and other AHPs, all of whom were involved in the assessment, planning and delivery of patient care.
- We observed a 9am ward round on the stroke unit, which was attended by consultants, nurses and AHPs, including neuropsychology and occupational therapists. Items discussed related to arrangements for patients medically fit for discharge, a referral being made to the pain team for one patient and a new patient transferred from another hospital needing to be medically assessed.
- Staff of all grades told us that joint and collaborative working was effective, especially between nursing and medical staff. A ward clerk that we spoke to on the MRU described there being "no hierarchy within MRU" and "all staff treat you as equals". Doctors and Nurses were described as being very approachable and supportive when needing to ask them something.
- 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 to 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. The renal and diabetes and endocrinology service had no consultant cover during the day at weekends, however medical reviews were escalated to medical registrars who could contact a medical consultant on-call. Junior doctors and nurses told us on-call consultants were quick to respond and they usually arrived on site within 30 minutes.
- The pharmacy team were available from 9-5pm Monday to Friday and provided a 9-12pm service over the weekends. Nursing staff the view that their weekend opening hours should be extended, as existing hours were causing delays in discharges.

- Improvements had been seen in accessing diagnostic services, with scans and reporting being completed outside of core working hours and at weekends.
- 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 was not always at establishment. 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.
- Physiotherapists worked from 08:30am to 16:30pm Monday to Friday with a rapid response team stationed in the MRU and ERU over the weekend.
- There was one OT working from 8.30am to 16:30pm on a Saturday and Sunday and they covered the MRU, ERU and Harvest Ward A (Elderly short stay ward).

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 these were not the latest versions in many cases.
- Staff had access to national guidance on ward computers, which had internet access. They told us this was invaluable for accessing NICE guidance and other key reference documents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were familiar with Deprivation of Liberty Safeguards (DoLS). We saw evidence of DoLS assessments and applications in use on the medical wards. Appropriate capacity assessments had been completed prior to the application of DoLS. Staff told us the safeguarding team played a key role in the logistics of obtaining permission for DoLS.
- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Advisor, 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 capacity advocacy and the MCA itself. This was now part of mandatory training, with 95.1% having completed this training within the last year.
- On Sunrise Ward B, we observed a physiotherapist checking the capacity of an elderly patient living with dementia.

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).
- All wards had a performance noticeboard on display which showed the most recent FFT scores.
- 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 Experience Survey 2015.

Compassionate care

- Patients were treated with respect, including when receiving personal care or undergoing any invasive procedure. Patients that we spoke with felt that their privacy and dignity was respected at all times. They reported that they were always treated with courtesy

when receiving care. On the CCU ward, we observed staff drawing curtains round beds for procedures and then explaining to the patients what they were going to do.

- The staff were kind, caring and compassionate, and had positive relationships with patients. Patients held staff in high esteem, especially nurses. One patient described a nurse as "charming" and another patient described the nurses as "providing excellent care". A patient staying on the ERU Ward spoke of nurses and doctors being "really good, friendly, confident and considerate". A relative visiting a patient on Sunrise Ward B mentioned there, "always being a member of staff to ask if you have questions" and added that "pleasant and dignified care [was] given by staff".
- From what we were told by patients and what we observed whilst on inspection, staff respected patients' individual preferences, habits, culture, faith and background. One patient told us that she had been offered a Caribbean menu at meal times.
- We saw examples of thank you cards displayed in the ward areas, with an overwhelming number of cards pinned to a noticeboard on Mandarin Ward B, thanking staff for their friendliness, compassion and hard work.
- We observed a positive interaction between a patient and a physiotherapist. The physiotherapist first used cleaning wipes to thoroughly clean a chair before seating a patient. They gently put down the patient and asked if she was warm enough and sufficiently comfortable. They brought the tray up to the chair so patient could reach drink. The physiotherapist gave the patient praise and affirmation and said goodbye.
- All wards had a performance noticeboard on display which showed the most recent FFT scores. The NHS Friends and Family Test (FFT) response rate was 34% between June 2015 to May 2016, against an England average of 30%. Most wards were scoring recommendation scores comparable to the England average of 96% (May 2016). Between March and May 2016, the Coronary Care Unit ward scored 97-100%, Harvest A ward scored 95-98% and Sunrise B ward scored 90-98%. In July 2016, Mandarin Ward A had a response rate of 27.4% but 94.1% of patients surveyed said they were likely to recommend the ward. The ward scored highly in a number of measures such as dignity and respect (4.67 out of 5), nurse communication (4.52 out of 5) and staffing (4.67 out of 5). Individual comments about the ward were, "staff are very kind" and "the care I was given was great / I was well informed and treated with kindness".
- The trust participated in the National Cancer Experience Survey, which was published in July 2016. For 2015, 1033 eligible patients from the trust were sent a survey, and 634 questionnaires were returned completed. This represented a response rate of 62%, against a national average of 66%.
- We read a comment card on the ERU which said, "there is a lovely HCA on the ERU – she is a credit to the ward, nothing is too much trouble".
- On Sunrise Ward B, a patient's daughter told us that she had been impressed by the level of care her mother had received and confirmed that her mother had been able to get some rest.

Understanding and involvement of patients and those close to

- All the interactions we observed were appropriate and clinicians delivered information in ways that patients could understand. Future plans were always agreed in partnership with the patient, such as follow-up appointment dates and treatment plans.
- On Harvest Ward B, we observed an allied Health Professional (AHP) undertaking a falls risk assessment. They were walking up and down the corridor with the patient, asking how they normally mobilise. They frequently checked the patient was okay but equally, let them be independent.
- On Harvest Ward A, we saw an AHP clearly introducing themselves to an elderly patient living with dementia, speaking clearly and loudly, confirming actions and explaining what they were going to do next.
- We watched a doctor pull the curtains round for privacy when reviewing a patient. The doctor took history and the patient's daughter contributed where necessary, as her mother was living dementia. The daughter raised concerns which the consultant addressed appropriately. The daughter then expressed that it felt like her mother had "given up" and deteriorated. The doctor spoke to the patient

clearly, asked permission to touch her and explained what was happening. They also explained the future course of treatment and management to the patient's daughter.

- In the National Cancer Experience Survey, 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. Of those who responded, 84% of patients said that, overall, they were always treated with dignity and respect whilst they were in hospital.

Emotional support

- The chaplaincy service provided good support for patients and relatives. We heard that it was accessible and the team responded promptly when requested. Chaplains were representative of several major religions including Church of England, Baptist, Roman Catholic, Islam, Judaism, and Sikhism. There were two prayer rooms available at Queen's hospital, with ablution facilities available in one of the multi-faith prayer rooms.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required. The National Cancer Inpatient Survey 2015 showed that 75% of respondents said that hospital staff gave them information about support groups (against 83% nationally).
- In the National Cancer Experience Survey, 92% of patients surveyed said that they were given the names of a clinical nurse specialist who would support them through their treatment.

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 slightly from the previous year. One ward in particular, Mandarin A, experienced a high number of bed moves occurring out of hours (between 10pm and 6am) in the months July and August 2016. 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.
- 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. 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 consistently failing to meet targets relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance.
- 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.
- The risk register highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards.
- Patient information leaflets were not standardly available in languages other than English.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.

However

- Diagnostic waiting time indicators were met by the trust every month between May and August 2016. Over 99% of patients waited less than six weeks for a diagnostic test.
- The average length of stay for all elective and all non-elective patients was below the England average.

- 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.
- Catering menus offered many options to cater for those with different nutritional requirements.
- Posters for communicating with patients with a hearing impairment were displayed on notice boards and deaf awareness training was also offered to staff on all wards.

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.
- Most 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.
- 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. 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

- Bed management meetings, attended by senior staff, were held three times a day to discuss and prioritise bed capacity, patient flow issues and discharges.
- Patients were not always able to be located on the specialist ward appropriate for their condition. On the day of the unannounced inspection, the CCU had eight medical outliers (patients admitted to a ward that is not suited to meet their needs). The CCU had previously lost four of its beds to the high dependency unit (HDU), so outliers were common. However, the medical team always tracked and reviewed outlying patients.
- Data demonstrated that 835 (3% of) inpatients were moved four or more times per admission between September 2015 and August 2016. This had increased slightly which was proportionate with a 12% increase in number of admissions across the division since the previous inspection. On one ward, Mandarin A, a high number of bed moves were occurring out of hours (between 10pm and 6am). Data showed that 60 patients were moved during this time during July 2016 and 73 patients during August 2016. One patient on Harvest Ward A told us that they had been moved between three wards over the course of just two days. 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 Queen's hospital, the average length of stay for all elective and all non-elective patients was below the England average.
- The trust did not submit any referral to treatment time (RTT) data to NHS England in the reporting period (Jun 2015 – May 2016).

Medical care (including older people's care)

- 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.
- 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.
- 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 standard, achieving 98.4%.
- The risk register highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards. This was causing poor patient experience, poor clinical outcomes, as well as poor patient flow throughout the division. The trust target of 40% of patients to be discharged between 8am and 12pm was not being achieved in the year September 2015 to August 2016. In August 2016, the ERU was only able to discharge 3.49% of its patients and Sky Ward A only 4.26% of its patients during the 8am to 12pm window. A matron on Mandarin Ward A told us that delayed bed discharges were common but were mainly attributable to placements to care homes and packages of care not always being readily available. The specialist medicine division was currently working on an early discharge flow programme to address excessive lengths of stay

Meeting people's individual needs

- Wards used a blue and white butterfly symbols on patient information boards to indicate whether a patient had a diagnosis of dementia or delirium respectively. 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. 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 and dementia link nurses were available for support and advice.
- 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.

- There were dementia carers and relatives coffee mornings, provided by the dementia team on a monthly basis. The purpose of these coffee mornings was to provide information and support to carers and relatives of patients living with dementia.
- We saw a 'Top 10 Tips' posters for communicating with patients with a hearing impairment pinned to staff notice boards. Deaf awareness training was offered to staff on all wards, with a training date schedule running from 2016 to 2017.
- We were told that patients with a diagnosis of learning disability (LD) would be issued with a specific LD folder and would have an LD Link Nurse (a specialist nurse who supports people with a learning disability while they are in hospital, to make sure they get the care they need). Each patient would be issued with a hospital passport. Hospital passports were designed to give hospital staff helpful information, that was not only about illness and about health, but could also include a list of patient's likes and dislikes, favourite type of food and drink, as well as their interests. Patients with an LD diagnosis would be checked on a daily basis by a matron, though there were no LD inpatients on the wards during our inspection.
- Patient information leaflets were not standardly available in languages other than English. However, we observed a patient folder on Harvest Ward B which had surveys in it with different languages such as Albanian, Bengali, Polish, Portuguese, Romanian, Punjabi, Tamil, Turkish and Urdu. The surveys were also available in different formats for LD and braille. Face-to-face and telephone translation services were available, which we was told was used primarily when seeking consent from patients. Most staff were aware of how to access these services and we were told that on occasions staff members would translate for patients. Some nursing staff told us that family members could communicate on behalf of patients whose first language was not English. However, there were a number of issues with this, such as potential unreliable information transfer, a patient who is subject to a safeguarding referral (where a family member is suspected of being involved in the patient's abuse), a reluctance to deliver bad news and unfamiliarity with medical terminology.
- 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.
- Patients were assessed for anxiety and depression on admission. Staff were aware of how to access support from the psychiatric liaison team for patients requiring intervention.
- A 'sage and thyme' communication skills training course was offered to staff, which taught core skills in dealing with people in distress.

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. We were told by staff that a member of the PALs team would visit the wards daily to speak with staff and patients, regarding any issues the patients may have around their care and treatment. Staff felt that this arrangement worked very well and as a result, not many concerns and complaints were lodged in respect. There were leaflets throughout most wards detailing how to access PALS and make a formal complaint.
- The acute and specialist medicine division as a whole received 263 complaints between October 2015 and September 2016. Analysis across the trust showed that the top themes of complaints were treatment, communication, diagnosis and staff attitude.
- The trust reported that it was currently 100% compliant with acknowledging written complaints within three working days. PALS attempted to respond to verbal complaints within five working days, but would agree a final timescale with the complainant in each individual case. 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.
- Lessons learnt from complaints and PALS enquiries were discussed at Divisional Quality and Safety meetings. This enabled those staff not directly involved in the complaint or the care of the patient to understand what had happened and to reflect on whether a similar situation could occur in their service.
- Four complaints were referred to the Parliamentary and Health Services Ombudsman (PHSO) between October 2015 and June 2016. This suggests that some patients felt that their complaints were not handled in a satisfactory manner by the trust.

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.

However:

- The NHS staff survey results were variable, with the trust still scoring below the national average in many measures.

Leadership of service

- The trust had restructured the management of the service in 2015/16, establishing six clinically led divisions, each with a divisional 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.
- We heard very positive comments about leadership across all of the specialities. A number of matrons were complimentary about the new Chief Nurse, and told us there had been improvement in leadership. On the oncology and haematology ward, nursing staff told us that there was an excellent consultant lead, who showed strong awareness in relation to new developments.
- Staff on the wards spoke highly of the ward managers and matrons, who were always available and approachable to provide help and advice. On the CCU, the ward manager was described as being a "fantastic" leader who "gets stuck into clinical care".
- Staff felt that unlike before, there were now clear escalation channels to the directors and divisional managers and executives were much more visible on the wards. Only one member of staff had never seen the senior executives come to their ward. The Chief Executive was described by a matron as "a fantastic leader".
- Senior managers said they were well supported and that there was effective communication with the executive team. We spoke to a ward manager on the ERU who expressed that he had a strong sense of accountability and responsibility for his ward.

- 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.

Vision and strategy for this service

- Most staff were able to describe what the trust's PRIDE values were and we observed staff carrying a 'pocket-sized' booklet with the trust's values attached to their lanyards.
- The trust had adopted a set of values based on their partnership 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 all 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 not being met.

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.

- On Mandarin Ward A, we were told that mechanisms for clinical governance and reviewing the service's own practice were much more rigid than four years ago. Clinical governance meetings had been occurring monthly up until June 2016, but were now occurring every two months. The meetings were attended by consultants, junior doctors, clinical staff and a member of the divisional team.

Culture within the service

- Across all wards staff consistently told us of their commitment to provide person-centred care, and spoke positively about the care they delivered. Staff understood their responsibility in putting patients first and incorporating the trust's values into caring for patients.
- There had been an improvement in the culture at the trust. Most staff we spoke with commented on how supportive staff of all levels were, and how the trust had become a better organisation to work in.
- Most staff felt listened to and involved in changes within the trust; staff felt confident that any issues or concerns that they took to matrons or senior managers would be listened to and dealt with.

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.
- 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.

- A 'terrific ticket' initiative had been introduced across the trust, which rewarded staff members for good practice and for those who went over and beyond in their line of work. We were told of a nurse who had been issued with a terrific ticket because she had demonstrated the PRIDE values, her documentation had been completed well and had been, calm, friendly and polite.

Innovation, improvement and sustainability

- The trust was chosen as one of five trusts in the country to be mentored by a consulting organisation on patient-centred care 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.

Services for children and young people

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

Information about the service

Services for children and young people at Queen's Hospital include an inpatient ward with 30 beds, a day case ward with 14 bed bays, a paediatric outpatients unit with two dedicated phlebotomy rooms and a neonatal unit with 25 beds. The outpatients department offers a range of specialist services including audiology and orthodontics. The neonatal unit is classified as level two by NHS England for the high level of patient acuity it can treat and has four high dependency unit cots, seven intensive care cots, 14 special-care cots and one cot reserved for emergency admission through an agreement with an ambulance service.

Ward areas and units are well equipped for young people with indoor and outdoor play areas, dedicated play specialists, sensory rooms and equipment and a wide range of toys for all ages. There is dedicated support for adolescents and for transition services when young people move to adult services.

In the 12 months prior to our inspection, the hospital treated 6520 paediatric inpatients and 11200 paediatric outpatients. Most inpatients were admitted due to an emergency, with a smaller number admitted on an elective basis. Between September 2015 and August 2016, the neonatal unit reported an average occupancy rate of 91%. In the same period the inpatient ward, Tropical Lagoon, reported an average occupancy rate of 67%. This does not take into account when beds are closed so that staff can provide a higher ratio of nursing care for patients with high dependency.

To come to our ratings we spoke with 39 members of staff including doctors and nurses of all grades, phlebotomists, play specialists, multidisciplinary team staff and senior divisional staff. We also spoke with 11 parents or relatives and looked at 27 patient records. We visited every area of the hospital in which services for children and young people are provided and looked at over 40 other pieces of evidence, including audits, risk assessments and improvement programme documentation.

We last inspected services for children and young people in July 2015 and rated the service overall as requires improvement. This reflected gaps in safety checks on safety equipment, a lack of audit activity that benchmarked performance against national standards and a lack of clear vision and strategy.

In addition to our announced inspection, we returned to the hospital on a weekend for an unannounced inspection on 15 October 2016.

Services for children and young people

Summary of findings

- There was clear and sustained improvement from our previous findings. This included the implementation of an audit programme that led to benchmarking of care standards and improvements in practice.
- There was improvement in learning from incidents and how these were communicated with staff, including examples of changes in practice and policy as a result of learning.
- Improvements had been made in nurse staffing levels, with an increase in recruitment and a reduction of turnover. Although there was still a vacancy rate of 11% in the nurse team, 15 new staff nurses were due to start and an overseas recruitment programme had been successful in attracting qualified nurses to the hospital.
- Medical staffing levels were consistently good and medical care was consultant-led, with support provided by other clinicians with appropriate training and specialist knowledge.
- Safeguarding procedures were robust and embedded in clinical practice and a system of meetings, staff training, supervision and audits acted as checks and balances to ensure children were protected from avoidable harm.
- Services were benchmarked against the guidance and standards of national health organisations as a measure of good practice. This included audits of the care received by patients with diabetes and epilepsy. The outcomes of audits resulted in improvements to the service.
- Practice development nurses provided support in staff development including competency assessments, training sessions and one-to-one support. In addition, staff were provided with the opportunity to develop specialist link roles. This represented part of a broader programme to encourage staff training and development.
- A weekly multidisciplinary psychosocial meeting ensured patients with complex needs or those who needed community social support were reviewed by a specialist team. Staff used this meeting to plan complex discharges, review safeguarding alerts and ensure care and treatment met individual needs.
- Feedback from patients and their parents was consistently good in the trust's in-house 'I want great care' survey. Staff demonstrated kind, compassionate and friendly care in all of our observations and all of the parents we spoke with told us they were happy with the service.
- Services were planned to meet the needs of the local population. This included Saturday outpatient clinics, a daily phlebotomy service and a weekly visit from a peripatetic local authority school teacher.
- Two dedicated play specialists and two play workers were available in Tropical Bay and Tropical Lagoon wards and children had access to a range of activities, equipment and toys. This included two indoor play areas and a secure outdoor play area attached to Tropical Lagoon. A sensory room and mobile sensory equipment were also provided.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.
- Transition services were in place for when a child moved into adult services. This was a structured approach that provided patients with gradually increasing levels of independence followed by the support of both children's and adult's nurses as they moved.
- Clinical governance structures enabled staff to monitor risks to the service and involve patients and staff in improvements. This was achieved through various means including a patient safety summit, clinical safety and quality meetings, whole unit team meetings and the use of a risk register to track changes in risk status.
- Changes to leadership in children's services had been well received by staff and as part of the trust's ongoing improvement programme, a new lead nurse was due to join the hospital in January 2017 with a remit of improving communication between hospital services and the care of young people.

Services for children and young people

- Staff were encouraged to provide feedback on their work and hospital policies and this was acted upon. In addition, staff with an interest in research were supported to participate to help inform innovative practice.

However:

- Environmental safety and waste management standards were not always consistent. This was because access to areas used to store sharps bins and waste was sometimes uncontrolled and there was a lack of compliance with fire safety guidance in some areas.
- Multidisciplinary staff did not attend nurse and medical handovers or ward rounds and short staffing in therapies teams meant there was inconsistent input from physiotherapy and dietetics and no occupational therapy service. This was evident in the inconsistent standards of nutrition risk assessments in patient records.
- Local audits identified documentation of consent to treatment as an area for improvement. Nursing staff were aware of this and handovers included a discussion of which patients had consent forms completed.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- There was scope to improve compliance with standards for infection prevention and control and hygiene including cleaning schedules, decontamination, record keeping and audits. Although we saw staff adhere to good infection control standards in practice during our inspection, performance in hand hygiene results in Tropical Lagoon were variable against the trust target of 90%.
- Environmental safety management was inconsistent. This included unsecured areas used to store items that could be dangerous to children, including sharps bins, chlorine tablets and clinical equipment. This was evident in more than one area with limited staff oversight of the problem until we escalated it to a senior person and therefore presented a significant safety risk.
- Although the senior team monitored staffing levels twice daily, the neonatal unit (NICU) did not always meet the minimum staffing requirements of the British Association of Perinatal Medicine.
- Fire safety standards on Tropical Lagoon and in areas around the NICU were inconsistently maintained. This included variable understanding from staff on emergency procedures, fire doors repeatedly wedged open and a lack of clear signposting for the location of fire extinguishers. In addition, there was limited learning from a previous fire and the most up to date fire risk assessment in 2014 had no documented update to actions identified. Areas of high risk for fire in the vicinity of the NICU were unattended with fire doors forced to remain open.

However:

- Staff spoke positively about the system for reporting and investigating incidents and for finding out about the outcomes. There were changes in practice based on learning from incidents, including improved clinical safety processes and ward security.

- Standards of infection prevention and control we observed were good, including appropriate hand-washing, use of hand gel and personal protective equipment.
- Equipment and bedside safety checks were completed at the beginning of each shift and there were procedures in place for staff to obtain technical support quickly in the event of clinical equipment failure.
- Standards of medicine management were good and there were dedicated pharmacists in paediatric inpatient areas. Prescribing and management were in line with British National Formulary for Children.
- Patient records indicated risk assessments were completed on admission and updated accordingly, including comfort observations. The quality of patient records was audited on a quarterly basis and the latest results for Tropical Lagoon indicated 100% compliance with trust standards.
- Safeguarding systems and processes were in place to help identify children and young at risk of avoidable harm. This included regular multidisciplinary meetings, supervision sessions delivered by the safeguarding team and monthly strategic dashboards that enabled staff to monitor referrals and patient outcomes. Training and staff knowledge were audited and the results used to improve delivery.
- Compliance with mandatory training met or exceeded the trust's 90% target with the exception of adult basic life support and paediatric newborn baby basic life support.
- Systems were in place to respond to deteriorating patients using the paediatric early warning scores system and availability of a paediatric intensive care transfer service. A dedicated transfer stabilisation bay was available in theatres to ensure patients were prepared appropriately prior to a transfer.
- Nurse staffing levels were affected by a vacancy rate of 11% and a turnover rate of 15%. Recruitment to reduce the vacancy rate was on-going and staff worked flexibly to help ensure all shifts were safely staffed according to a safer staffing tool. Agency staff were often used to help fill shifts and there was a process in place to ensure they were appropriately qualified and clinically competent.
- Medical care was consultant-led and doctors of appropriate grades and experience were available 24-hours, seven days a week. Medical and nursing handovers were comprehensive and consistent, with detailed reviews of patient needs.

Incidents

- Between July 2015 and July 2016 there were no never events in medical care services. 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. In the same period, two serious incidents were reported in accordance with the NHS England Serious Incident Framework. Both incidents had been investigation with a root cause analysis and the outcomes shared with staff.
- Staff used an electronic system to report incidents. Senior staff assigned these to an appropriate investigator who completed an investigation into the cause of the incident and an assessment of any harm or near misses that occurred. All of the staff we spoke with said they felt confident in submitting incident reports and said they were happy with how these were dealt with. Senior staff in each area shared learning or changes in practice or policy as a result of incident investigations with their team through daily handovers and safety briefings, notices in staff areas and by e-mail. As a result of incident investigations, a number of changes had been made in Tropical Lagoon ward to improve safety and reduce risk. For example, nurses completed bedside equipment safety checks as part of each handover and a new daily checklist was introduced for resuscitation equipment.
- Senior staff had improved security on Tropical Lagoon ward as a result of learning from an incident investigation that involved the unauthorised removal of a patient. The incident was investigated with appropriate support from social services and the police and as a result a double-locking electronic security system was installed. This meant visitors could only access and depart the unit when the doors were released by staff. During our inspection staff demonstrated a good awareness of this security system. For example, one relative used the intercom to request access to the unit and the ward clerk noticed from the

security camera that other people were with them. This member of staff verified each person's identity before allowing access. However, this was not a failsafe system. For example, on three occasions we observed people tailgating others into the unit without being noticed by staff. Staff who worked in the unit accessed it through a separate entrance to reduce the risk unauthorised people would follow them in or out.

- Agency nurses did not have access to the electronic incident reporting system at the time of our inspection. However, the child health service delivery manager was planning to introduce incident reporting processes for agency nurses imminently. We spoke with an agency nurse about this. They said they were aware of the system and could approach the nurse in charge of any shift who would facilitate their access if they needed to make a report.
- Where an incident involved a child who held a hospital passport for communication or complex needs support, the cause and outcome of the incident were documented in the passport. Staff used this to increase their awareness of risks and to modify their practice to avoid another incident.

Cleanliness, infection control and hygiene

- Cleaning services were provided by a contractor who assigned staff to the same areas as often as possible for consistency. This enabled their staff to become familiar with cleaning standards and requirements in specific areas. All of the facilities in children and young people's services were visibly clean and tidy during our inspection. Staff told us the cleaning contractor was responsive to their needs and an on-call supervisor was always contactable by phone if they needed urgent cleaning. However, it was not clear that regular and robust checks were in place for the cleaning of facilities outside of wards. For example, there were two toilets in the waiting lobby of Tropical Lagoon ward. On one day of our inspection, one of the toilets did not have toilet paper and the other toilet was soiled and unfit for use. This had not been reported and we escalated it through the nurse in charge in Tropical Lagoon. The cleaning supervisor attended within one hour and a nurse displayed a sign advising people not to use the facilities but this was an ad-hoc system that did not follow the trust's service level agreement with the contractor. For example, the cleaning supervisor told us they needed a reference number to track problems like this and ensure resources were directed to areas of greatest need. As this had no happened it was not possible for them to find out how long the facilities had been out of service.
- Staff in the neonatal unit screened each baby for methicillin-resistant Staphylococcus aureus (MRSA) on a weekly basis. Two cubicles were available to provide extra infection control for babies where MRSA colonisation had been found.
- Play specialists followed a cleaning process for toys including a decontamination process for toys used by children with an infectious condition. This involved decontaminating toys in a bath, which presented the risk the bath surface could be infected. We spoke with a senior nurse about this who told us the bath used for decontamination was never used for bathing children. The cleaning schedule was ad-hoc and there was no documented standard for how often this should take place to reduce the risk of cross-infection.
- Staff followed a three-part decontamination process for endoscopes and other equipment used during ear, nose and throat procedures. This meant cleaning and decontamination processes met the national guidance of the
- A senior sister conducted monthly hand hygiene audits that assessed staff practice against trust policy. Between October 2015 and October 2016 Tropical Lagoon ward performed variably against the trust target of 90% with monthly results ranging between a minimum of 60% and a maximum of 100% without a trajectory of on going improvement. Although this result indicated a need for improvement, during our inspection we saw staff made good use of alcohol gel, hand washing facilities and the use of personal protective equipment.
- Housekeeping supervisors conducted weekly audits with cleaning staff to assess standards of environmental cleanliness.
- Each ward or unit had clear information on display that encouraged parents and visitors to follow infection prevention and control procedures by providing straightforward instructions and an explanation of why this was important. For example, information on Tropical Lagoon included an explanation of the bare below the elbows policy and how this helped to prevent the spread of infection.

- Staff used green 'I'm clean' stickers to indicate when an item of equipment had been cleaned and disinfected and was ready for use. This process was used consistently and we saw it applied to all equipment that might be used with patients.
- In Tropical Lagoon the quality of care board included information on methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C.Diff) infections rates and indicated there were no new infections in the previous month.
- Cleaning records and checklists were in place for most decontamination processes, including weekly steam-cleaning of commodes. Documentation was not always up to date. For example, there was a 17 day gap in completion of the commode cleaning schedule. We asked a nurse about this who said they said commodes regularly being cleaned but it was the responsibility of the cleaning contractor to complete paperwork for this.
- An infection control link nurse was in post on Tropical Lagoon and in the neonatal unit who monitored the results of cleaning and hand hygiene audits and conducted monthly checks of decontamination processes and effectiveness. Link nurses attended three-monthly infection control meetings to discuss trends in audits or unusual issues.

Environment and equipment

- Staff in each clinical area used a structured 'fit to fly' process at the start of each shift to ensure the environment was safe to operate. This included checks that sharps bins were not full and the availability of equipment and documentation.
- Nurses completed a bedside equipment safety check at the beginning of each shift, including making sure oxygen was available and working.
- Resuscitation trollies were available in all paediatric areas and staff documented daily safety checks on these. An emergency grab bag was additionally available in Tropical Lagoon ward and staff documented daily checks on this.
- Each cot in the neonatal unit was equipped with a ventilator and an additional portable ventilator was available. The manufacturer was able to respond to urgent equipment failures and staff used a yellow card system to indicate to senior staff when they experienced a problem with equipment.
- Staff documented safety checks on neonatal equipment on a regular basis. These included twice daily checks on incubators and a monthly defrost of breast milk freezers. Staff also documented daily temperature checks of breast milk fridges.
- There were four blood gas machines available for neonatal services located in appropriate areas including the HDU, the labour ward and the emergency department.
- Environmental risks were not always well managed. For example, on one day of our inspection, we found the treatment room on Tropical Lagoon ward to be unlocked and unattended by a member of staff and a container of acetone was stored in an unlocked cupboard. In addition, we saw a personal mobile phone was plugged into a power supply and left unattended on top of laundry equipment in the neonatal unit. This presented a fire risk.
- During our weekend unannounced inspection we found a treatment room on Tropical Bay to be unlocked and used to store a 22 litre sharps bin on the floor with an open aperture. Syringes and sodium chloride were also visible and easily accessible. This presented a health and safety risk as the unit had only two members of staff and access to this room was unmonitored. The playroom door in this area was a fire protection door that should be kept closed at all times and had a notice posted to advise this. However, we found the door to be wedged open and the playroom unattended. The disposal room was unlocked, unmonitored and contained three full sharps bins stored on the floor instead of being disposed of in the yellow waste truck. We spoke with the senior nurse on the unit and the site manager who secured this area immediately. Responsibility for waste disposal areas was held by contracted staff and it was not clear what arrangements were for monitoring the safety of their work because of the number of unmanaged environmental risks we found. On the same day, a children's outpatient clinic was in operation. A consultant, senior nurse and receptionist were in attendance but access to all areas of the unit was not controlled. We found multiple

treatment rooms and areas unlocked, including two soundproofed audiology suites, which presented a potential health and safety risk if a child was to access the area unnoticed.

- A store cupboard on Tropical Lagoon ward had a sign posted that stated the room was used to store chemicals and should be kept locked at all times. During our weekend unannounced inspection this room was unlocked and unsupervised. The cupboard did not contain chemicals subject to the Control of Substances Hazardous to Health regulations but did contain floor cleaner and a shelving structure that was stocked to capacity and had partially buckled. This presented a health and safety risk to anyone who accessed the room. Staff we spoke with were not able to explain why the cupboard was unlocked. This meant the cleaning contractor did not have a robust safety system in place for this area. On the same day, the dirty utility room on Tropical Lagoon ward was unlocked. There was a sputum sample pot on a surface top that contained an unidentified liquid and was unlabelled. This meant there were not seamless processes in place for the labelling and control of samples. We also found on this day the dirty utility room in the neonatal unit was unlocked and three containers of chlorine solution were on display and easily accessible. The risks of a young person accidently ingesting this was controlled in part by the unit's strict access policy that did not allow anyone under the age of 12 in the unit.
- The clinical engineering department provided on-call technical support to staff when they experienced equipment failures or needed help with a malfunction. This team scheduled routine maintenance for equipment in clinical areas on a rolling basis to avoid causing interruptions to the service.
- A fire warden was in post on Tropical Lagoon ward and was responsible for communication with the central switchboard in the event of a fire alarm. If they were not on the ward, the nurse in charge took on this role although fire warden training was not common amongst this group. The trust's emergency fire safety officer had offered practical simulated fire and evacuation training to ward staff but this had not been taken up. Fire safety was part of the trust's mandatory training package and 88% of staff were up to date with this.
- There had been an electrical fire caused by misuse of a microwave in the parents' kitchen area in Tropical Lagoon. This area consisted of a kitchen, play equipment storage area, lounge and sitting area, with four fire doors in place between individual rooms and a lobby that connected to the ward. On three occasions during our inspection, including our weekend unannounced inspection, three of the four fire doors were wedged open. This meant in the event of a fire alarm the doors would not close and therefore not prevent a fire from spreading. There was no firefighting equipment in this area, including fire extinguishers or fire blankets. The nearest firefighting equipment was located at the nurse station on the main ward, which was not in the immediate vicinity. There were no notices to direct people to the firefighting equipment.
- We asked for the latest fire risk assessment for Tropical Lagoon. This was completed in February 2014 and found the unit to be fully compliant with safety legislation. However, this risk assessment was based on the ability to contain a fire in the unit with the use of closed fire doors and that a fire warden completed daily visual checks of this. The risk assessment recommended that fire escape signage be displayed more prominently in some areas of the unit. There was no documented update to indicate this had been completed. A fire risk assessment carried out in Tropical Bay in April 2014 recommended the same changes be made and there was no indication this had been completed at the time of our inspection. The trust told us an additional fire risk assessment was carried out after our inspection in October 2016, with no significant findings or updates.
- A secure corridor linked the NICU with the main hospital and contained a kitchen. On one day of our inspection we found both fire safety days between the corridor and the kitchen were wedged open and the kitchen was unattended. This meant if the fire alarm sounded, the automatic door closure mechanism would fail to operate. There was also no firefighting equipment in the kitchen. A member of catering staff told us there was no fire safety equipment in the kitchen and said they did not know where the nearest fire extinguishers were.

Medicines

- Dedicated paediatric cover was provided daily and a pharmacist checked each patient's drug chart on Tropical Lagoon ward each morning.

- The neonatal unit and Tropical Lagoon ward both had an electronic medicine dispensing system in place with fingerprint access control for security. This meant only authorised staff could access medicines. Staff in Tropical Lagoon said this system worked well and meant they could more easily keep track of stock and ensure medicine was within its expiry date. A senior nurse conducted a full weekly stock check of medicine expiry dates. Staff on the neonatal unit said that ordering processes were slow and they could sometimes wait up to 48 hours for restocking after they placed an order although we did not see any formal incident reports relating to this.
- Staff prescribed and administered medicine in accordance with the British National Formulary for Children.
- Access to medicine storage areas was controlled. For example, the medication room in Tropical Lagoon had key-coded access and cupboards used to store to take away medicine or patient's own medicines were locked. Controlled drugs were stored in locked cupboards according to national safety guidance and staff documented twice daily stock checks.
- Staff documented daily temperature checks on medicine fridges to ensure items were stored with manufacturer's safe guidelines.
- We found expired iodine solution and expired blood culture bottles stored in a treatment room in Tropical Lagoon ward. Staff told us they checked expiry dates before each used but it was not clear why the stock rotation system had not identified the items. The senior nurse on shift disposed of the expired items.
- As a result of learning from an incident, staff no longer photocopied drug charts. This meant there was no risk medicine doses would be duplicated.
- A pharmacist had worked with the paediatric team to introduce a protocol for the use of 'to take away' medicines in Tropical Lagoon. This enabled staff to discharge patients with medicine without the need for them to visit a pharmacy straight away and enabled the hospital pharmacy team to support staff to implement and monitor this safely.

Records

- Most paper records were in paper form and were shared by the medical, nursing and multidisciplinary teams. Most of the records (26 out of a total of 27) we looked at were well ordered and organised.
- Clinicians did not always clearly identify themselves in patient records. For example, in 15 patient records we looked at on Tropical Lagoon, we had to ask staff who had made entries in notes as they had not included their designation or their name was illegible. In six more records, this information was legible inconsistently.
- In February 2016 staff in Tropical Lagoon conducted an audit of the quality of patient records against 10 standards, including the completion of demographic data and information relating to child protection. The audit indicated 100% compliance with a number of actions in place to ensure continuing standards, including training for agency staff and an improvement in induction processes. This audit was repeated in June 2016 and the results indicated consistently high standards. Staff identified new admissions paperwork as a positive initiative and recommended new staff be offered additional training on its completion.

Safeguarding

- A consultant for children and young people's services was the hospital lead for paediatric safeguarding. This member of staff offered monthly safeguarding supervision sessions and all staff involved in providing care to young people were invited to attend, with a requirement that staff attend three sessions per year. The supervision included opportunities to discuss shared experiences, reflections on practice, current challenges and to provide feedback on the quality of care. A safeguarding nurse audited attendance at safeguarding supervisions on a quarterly basis. Between April 2016 and June 2016, only 6% of neonatal staff attended all three supervision sessions and 32% attended one session. In Tropical Lagoon, 40% of staff attended all three sessions and 26% attended one session.
- Safeguarding staff used monthly strategic dashboards to monitor safeguarding practice and referrals, including for children with learning disabilities and autism. This

information was used to ensure referrals to specialist and social services were made appropriately, track staff training compliance and monitor the implementation of expected standards of care.

- Safeguarding was part of the trust's mandatory training programme and all staff in paediatric areas, both clinical and non-clinical, were required to complete basic safeguarding training. Nurses, play specialists and other clinical staff completed safeguarding children training to level three. At the time of our inspection, 100% of staff had up to date safeguarding level one training and 87% of required staff had up to date safeguarding level three training.
- In September 2016 the safeguarding children operational group evaluated the effectiveness of safeguarding children training amongst 115 staff. The evaluation found that training was effective in raising knowledge and confidence about the subject and that all staff achieved their training objectives by the end of it. Staff had requested more interactive learning opportunities, more involvement from external speakers and changes to training delivery to reflect different learning needs. As a result the safeguarding training team identified methods to make the training more accessible to staff with different learning styles and planned to involve social workers and independent domestic violence advocates in the training delivery.
- Tropical Lagoon was equipped with security systems to reduce the risk of abduction or unauthorised access. This included an electronic security access control system that required staff authorisation to enter and exit the ward.
- The senior sister on Tropical Lagoon had developed and implemented a new safeguarding audit tool following learning from a serious case review. The investigation highlighted that there were gaps in how children could be traced between hospital and community services. This was resolved by the new auditing tool, which enabled staff to keep more detailed continuous notes on the care and transfer of children between services.
- Ward-based staff worked closely with community and homecare teams to ensure patients or their relatives at risk of preventable harm had appropriate support or intervention. This included rapid referrals to the trust's domestic violence team and safeguarding lead nurse when they considered a visitor to be at risk of abuse.
- Each child cared for as an inpatient had a wristband with their personal details on it. We observed staff checked this at the beginning of each shift as part of a safety and safeguarding check.
- Safeguarding specialists were available in the hospital, including for responding to situations of domestic violence and sexual abuse. This team included a safeguarding paediatric liaison nurse
- Multidisciplinary safeguarding meetings took place monthly and included staff involved with delivering paediatric care on a case by case basis, such as the learning disability nurse. The multidisciplinary team also held weekly psychosocial meetings to review patients with safeguarding needs, including those with complex needs such as fabricated or induced illness, attempted suicide and self-harm. Staff included all safeguarding concerns in their review, including when parents had safeguarding needs and their children were cared for in the hospital. For example, if parents were known to be at risk of self-harm, staff used this meeting to liaise between services and ensure appropriate support measures were in place, including with services such as midwifery.
- Staff at all levels of responsibility and experience we spoke with demonstrated a detailed understanding of the principles of safeguarding, both for paediatric patients and visitors or parents who may also be vulnerable. We spoke with an agency nurse who was responsible for providing care to a patient on the child protection register. This member of staff demonstrated the knowledge and understanding to competently provide care and had support from the rest of the team in ensuring the patient was kept safe from avoidable harm.
- All nurses at sister level or above were trained to be safeguarding champions, which meant they attended additional training and meetings with the safeguarding team to ensure their knowledge and practice was up to date. A member of the hospital safeguarding team visited Tropical Lagoon on a daily basis and acted as a specialist point of contact for staff, including agency

nurses. This team conducted regular safeguarding audits of patient notes and new clerking processes had been introduced to help staff highlight safeguarding risks in patient notes.

- Safeguarding training included the recognition of female genital mutilation (FGM) and policy guidance was readily available for all staff on the intranet.
- Senior staff monitored compliance with safeguarding policies and practice through the use of a monthly dashboard. The latest data available to us indicated a 90% compliance rate with level three safeguarding practices.
- In April 2016, an audit took place of the safeguarding documentation and record keeping in the neonatal unit. The audit found a 100% increase in the number of safeguarding cases in the unit and 100% compliance with the use of correct documentation templates. However, there was a 54% decrease in the recording of patient identifiable data on every page of the paperwork and only 15% compliance with the recording of time and length of family visits. In response to the results, all new staff spent a full shift with the family care coordinators and safeguarding link nurse and each nurse away day included a safeguarding supervision.

Mandatory training

- Staff were given protected time on their rota to complete mandatory training. Tropical Lagoon had a training room that staff could use to complete online training and practice development nurses used this to deliver practical training sessions. Mandatory training included conflict resolution, equality and diversity, moving and handling and safeguarding.
- The trust target for up to date mandatory training was 90% of all staff. In July 2016, children and young people's services met or exceeded the minimum target in all areas except for adult basis life support (89%) and paediatric basic life support (83%).
- Senior nurses used an electronic training system to monitor the mandatory and statutory training of their teams. This enabled them to plan in advance for refresher training to help staff remain up to date. All staff not on maternity leave in paediatric outpatients had up to date mandatory training.

Assessing and responding to patient risk

- Staff in Tropical Lagoon ward used risk assessments including an emergency department transfer checklist and a measure of each child's level of responsiveness and consciousness. They also documented pain scores and the use of the sepsis 6 pathway. In all five sets of records we looked at during our weekend unannounced inspection, this information was completed.
- Each room or bed bay in Tropical Lagoon had a patient safety folder that included observation charts, safety rules and flow charts and protocols for specific procedures, such as stool collection. Staff also completed regular comfort rounds, which ensured patients were as comfortable as possible by checking bed position and access to equipment. We looked at 10 sets of notes in safety folders and found them to be clear and consistent.
- Staff used the paediatric early warning scores (PEWS) system to monitor patients for signs of deterioration. PEWS were completed at regular intervals based on the condition of the patient and staff escalated patients with an increasing score to an appropriate doctor. Each patient records folder included the protocol for caring for a child between one and ten years old in cardiac arrest, which followed Resuscitation Council (UK) guidance.
- Contingency transfer plans were in place in the event paediatric inpatient areas were full to capacity or could not adequately care for patients. For example, in the event of an infection outbreak on Tropical Lagoon, patients would be prepared, stabilised and treated on Clover ward before being transferred to another hospital. The hospital used a regional paediatric intensive care retrieval service to ensure transfers were safe and conducted by qualified staff.
- Staff used a weekly multidisciplinary patient safety summit to identify risks to patients such as through incidents, complaints, feedback from staff or staffing issues. This enabled the senior team to respond quickly to problems and put action in place to resolve them.
- All doctors and advanced nurse practitioners in the neonatal unit had completed a neonatal life support programme and staff across children and young people's services had life support training to a level appropriate to their role. Of all staff required to undertake paediatric immediate life support training,

100% were up to date. Of staff required to undertake newborn basic life support, 86% were up to date and 85% of staff who needed paediatric basic life support training were up to date. This fell short of the trust's 90% target for training completion.

- Staff used a paediatric sepsis 6 pathway to assess and treat sepsis as a clinical emergency according to the guidance of the UK Sepsis Trust. We looked at the use of the pathway in practice and found it to be used appropriately.
- We observed doctors in training demonstrate rapid, calm treatment for a child who began fitting in a cubicle and followed the trust escalation policy to notify a consultant. This showed us staff understood when to escalate urgent situations and that the related policy was embedded in practice.
- A paediatric transfer bay was available in the operating theatre recovery area that enabled staff to prepare a collapsed child for emergency transfer while awaiting the transfer ambulance. Recovery staff could manage difficult airways in this bay and a paediatric anaesthetist and paediatric nurse was always present when a child was in the bay.

Nursing staffing

- At the time of our inspection there was a nurse staffing vacancy rate of 11% and annual turnover of 15%. Nurse staffing recruitment to address vacancies turnover was ongoing, with 15 staff nurses due to start work in September 2016 and a programme of overseas recruitment underway.
- Where temporary nursing staff were employed on wards, the nurse in charge of the shift completed an induction checklist to ensure they were aware of local procedures, including escalation processes for deteriorating patients and local fire safety procedures. We saw this worked well in practice and records of completed inductions were stored locally.
- A senior sister led nursing care on Tropical Lagoon with the support of two practice development nurse coordinators along with a team of band six registered nurses. All permanent nurses on this ward were registered sick children's nurses. Shift leaders booked agency nurses regularly and tried to maintain consistency by securing the same nurses as often as possible. During our observations of handovers and care, agency nurses demonstrated they had the knowledge and skills to work with the permanent team and provide safe care. Paediatric inpatient services were led by a matron and this individual was temporarily seconded to an interim lead nurse role. A matron was in post for neonatal ICU.
- The nurse to patient ratio on Tropical Lagoon ward was established as 1:5 where patients did not have complex needs. In these cases staffing levels could be increased and patients could be cared for on a 1:1 or 1:2 basis where needed. A safe staffing protocol was in place and where the senior team identified safety risks caused by high levels of dependency from patients, they could close the ward to new admissions.
- Nursing staff on Tropical Lagoon held twice daily handovers and a play specialist attended the morning handover. We observed one handover and found it included a detailed safety brief about processes and care in the ward. The nurse in charge demonstrated a detailed knowledge of each patient and reviewed pain relief, early warning scores, safeguarding concerns and the involvement of external organisations, including social services.
- The neonatal unit maintained a nurse to patient ratio depending on the level of care provided. For example, patients in the neonatal intensive care unit (NICU) were cared for with a 1:1 nursing ratio; patients in the high dependency unit (HDU) were cared for with a 1:2 patient to nurse ratio and patients in the special care baby unit were cared for with a 1:4 nurse to patient ratio. Two full time healthcare assistants (HCAs) provided support in the unit, a clinical nurse specialist provided care in the NICU overnight and two advanced nurse practitioners were available.
- During our weekend unannounced inspection the NICU was full to capacity. A band seven sister led the nursing team of six registered nurses and one healthcare assistant. Staff were visibly very busy and a senior nurse told us they were short staffed and the team found the shift very challenging. The nurse in charge was not supernumerary to the staffing level as they had responsibility for patients as well. All neonatal nurses at band six or above had completed specialist post-registration training in paediatric critical care, which represented 68% overall.

- Nurse staffing levels were displayed in each ward or clinical unit and indicated the planned number of staff on the shift compared with how many staff were present. It was not always clear if this information was up to date or accurate. For example, on one day of our inspection the senior nurse in the NICU told us the unit needed a minimum of 10 qualified nurses to operate safely and that as they only had nine staff on shift, they felt the nursing team was under additional pressure. However, the nurse staffing information board indicated the planned number of nurses was eight and that eight nurses were on shift. We were not able to identify why there was a discrepancy in figures. Staffing levels in the NICU did not always meet the requirements of the British Association of Perinatal Medicine (BAPM). After out inspection the trust provided information to show that when the NICU was exceptionally busy or received several admissions at the same time, additional staff were provided to support the team.
- A business case had been approved to recruit an additional seven nurses for the HDU beds in the neonatal unit.

Medical staffing

- The trust reported their medical staffing mix of 65 whole time equivalent doctors in children and young people's services as 29% consultants, 12% middle career, 39% registrars and 19% doctors in training. This represented a lower number of consultants and registrars and a higher number of middle career and doctors in training than the national average.
- Medical care in services for children and young people was led by a team of 16 paediatric consultants, 10 general consultants with paediatric training, six neonatal consultants and an additional consultant assigned to cover the emergency department.
- All sick children admitted before 7pm were reviewed by a paediatric consultant. Between 7pm and 8am, a paediatric registrar reviewed each patient and a paediatric consultant reviewed them after this.
- All children admitted to the hospital through the emergency department or paediatric outpatients were reviewed by an acute paediatrician.
- Six consultants led medical care in the NICU along with four specialist registrars and five senior foundation doctors. This was below the number allocated to the unit by the deanery of eight specialist registrars and 10 foundation doctors. However, the unit was compliant with BAPM guidelines.
- On a weekend, one specialist registrar and one senior foundation doctor provided medical care on Tropical Lagoon ward and a consultant was available on-call.
- A specialist registrar and a senior foundation doctor provided medical cover to the NICU on a weekend, with a consultant available on call. This was to provide care and treatment for 24 babies with one additional bed available for an emergency admission. In other children and young people's services, up to six registrars were available between 8am and 5pm and one registrar was available until 9pm.
- A consultant paediatrician led a medical handover three times daily. We observed a handover and saw this was an inclusive process for doctors in training that offered a significant learning and educational element. The consultant discussed each child in depth and the handover was attended by the nurses responsible for each patient as well as the nurse in charge. Staff used the handovers to plan care for patients about to be admitted.
- Doctors we spoke with said they felt supported by consultants and were happy with opportunities for development. Permanent doctors told us they occasionally worked with locum staff and were happy with the induction process for temporary medical staff.
- A consultant reviewed each child at least once every 24 hours and we saw this was documented from looking at records.
- Doctors in training told us there were sometimes gaps in the rota due to sickness but two paediatric consultants from other hospitals often covered registrar or staff grade shifts when services were short staffed.
- Nurses and other clinical staff we spoke with all told us they found doctors to be accessible and readily available whenever they needed advice or guidance.

Major incident awareness and training

- Most staff we asked in children and young people's service areas told us they had not undertaken major incident or emergency training. One member of staff

said they had undertaken it but they were not sure how long ago it was or if what they learned was still valid. Staff told us procedures to follow in a major emergency were stored electronically on the computer system but they did not know if this had a secondary power supply in the event of a power failure. A fire log book was stored on the Tropical Lagoon and included space to record visual checks of fire extinguishers and door closing mechanisms and to document the staff cascade list in an emergency. The log book had not been filled in and two members of staff we asked did not know why this was the case.

Are services for children and young people effective?

Good

We rated effective as good because:

- Services consistently met the guidance of the Royal College of Paediatrics, which meant patients received timely and expert care from qualified staff.
- Care and treatment was benchmarked against national guidance and best practice from a number of appropriate organisations, including the National Institute for Health and Care Excellence (NICE), the Royal College of Paediatrics and Child Health and the North East London Perinatal Network. In addition, services contributed to national audits to establish the standard and quality of practice and patient outcomes in the context of national work. Outcomes from national audits were used to improve service provision and patient experience, including in diabetes and epilepsy care.
- Safety summits were used to identify areas for improvement in effective care and patient outcomes. For example, a consultant lead for paediatric anticoagulation had been appointed following a summit and plans to implement a clinic were underway.
- Services demonstrated a consistent improvement in results from the National Paediatric Diabetes Audit Patient and Parent Experience Measures between 2012 and 2016, with several measures of child or parent satisfaction rated as 100% in the latest data release.
- Investment had been made in new clinical equipment that would improve the care and outcomes of patients treated for respiratory conditions.
- Practice development nurses supported and worked with staff nurses and healthcare assistants (HCAs) to develop clinical and professional competencies. This included completion of the national care certificate for HCAs. Training was evaluated and improvements made in delivery based on staff feedback.
- There was a clear focus within the service on promoting the specialisation of staff, including through the development of link nurse roles and ability of doctors to take on specialist roles.
- Although there were gaps in the provision of some therapies, including occupational therapy, the hospital had made sustained progress in the increased provision of some services. For example, a paediatric epilepsy nurse had been recruited, a diabetes specialist team was in place and a dedicated paediatric dietician and pharmacist were in post.
- Working relationships with theatre recovery staff and emergency department staff had been developed through nurse rotation programmes and closer working between senior nurses and clinicians. This benefited patients because it meant more staff were trained and aware of the needs of children and young people when moving between hospital services.
- A weekly psychosocial meeting helped the multidisciplinary team to consider the complex needs of children and young people, including when planning discharge and liaising with community mental health services.

However:

- There was a lack of therapies staff available for children and young people, including in dietetics and physiotherapy. This was highlighted in the divisional risk register and had been in place since 2014. The impact of this included inconsistent documentation of nutritional risk assessments in patient records.
- Multidisciplinary staff and therapists were not routinely included in handovers or ward rounds.
- There was room for improvement in the consistent use of consent documentation in patient records.

Services for children and young people

Evidence-based care and treatment

- Staff demonstrated they had access to trust policies and national guidance on the intranet. There was good access to IT systems in all clinical areas to facilitate access.
- Services for children and young people met nine of the ten standards of the Royal College of Paediatrics and Child Health Facing the Future 2015 guidelines. This included an admissions review by a paediatric doctor within four hours and by a paediatric consultant with 24 hours, daily consultant-led handovers and level three child protection training amongst all clinicians. The guidance recommends a consultant always be available at peak times. Although consultant rotas did not evidence this, all of the doctors we spoke with said consultants routinely stayed on site longer than their shift. This meant services met this recommendation in practice but could not provide evidence this was always the case.
- Paediatric haematology and oncology support care protocols were based on collaborative work to benchmark standards from five organisations, including the London Cancer Network and the London Cancer Alliance.
- The neonatal unit was accredited by the UNICEF UK Baby Friendly Initiative, which benchmarked the support given to mothers and babies for breastfeeding against international best practice guidance.
- The neonatal intensive care unit (NICU) was part of the North East London Perinatal Network and used the relationships within the network to benchmark their work and patient outcomes against other units.
- Consultant paediatricians based care and treatment plans during ward rounds on specific National Institute for Health and Care Excellence (NICE) guidance as a strategy to help with the development and learning of doctors in training.
- The quality and safety manager had dedicated administrative support that ensured any updates to NICE guidelines were incorporated into trust policies and communicated with staff.
- The hospital participated in the 2014 British Paediatric Neurology Association Epilepsy 12 Round 2 audit to benchmark the quality of care standards for children and young people with epilepsy against national standards. Paediatric services achieved 85-100% of epilepsy 12 indicators and epilepsy 12 performance indicators and achieved 0% in one of epilepsy performance indicators. The audit outcome indicated the hospital should appoint an epilepsy nurse specialist, which had been achieved.
- Child safeguarding staff conducted 22 individual audits between September 2015 and September 2016 This included compliance with the use of safeguarding screening tools, identifying female genital mutilation and adaptation of the service for children with complex needs.

Pain relief

- Children and young people's services met the guidance of the Faculty of Pain Medicine's Core Standards for Pain Management (2015) in pain scoring, observation and treatment.
- A specialist pain team was available on call and their contact details were readily available at each nurse station in patient areas. Nurses we spoke with were aware of the team's role and knew how to contact them.
- A clinical nurse specialist and five nurses led a pain management team. This team included a paediatric associate nurse and used a pain care service referral pathway to review patients.

Nutrition and hydration

- Nutrition assessments were not routinely completed in patient records. We looked at 20 records and found a nutrition assessment in only four of them. We spoke with staff who said the input of a dietician was difficult because of short staffing in that service. This had been acknowledged by the divisional team as a risk since 2014.
- Following patient feedback and input from clinical staff, the food menu had been improved to include a wider, more nutritious range of food. This meant staff could meet the dietary needs of children as prescribed by the dietician or a doctor as well as offer food they liked. Snack boxes were available out of hours if a child missed a meal an.
- As part of the National Paediatric Diabetes Audit, the Patient and Parent Experience Measures survey asked

young people and their parents if they had been given enough time to discuss their needs with a dietician. In 2015/16, 100% of respondents said they had been given time with a dietician. This was significantly better than similar units in London and nationally and represented a steady improvement in responses since 2012/13. In the same survey, 86% of respondents said they had been given nutrition advice.

Patient outcomes

- The hospital performed worse than the England average in the paediatric diabetes audit 2014/15 with 12% of patients having an HbA1c balance of less than 58 mmol/l compared with the national average of 22%. The mean HbA1c of patients was 3% worse than the England average. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time and hospitals benchmark their performance against NICE quality standard 6, which states that a HbA1c balanced of over 58 mmol/l indicates a poorly controlled diabetes. In April 2015 the paediatric diabetes team published an annual report and clinical audit action plan to improve the trust's performance in diabetes care. This report acknowledged that some improvement had been made in the preceding two years and identified improved nurse education, psychologist input and more administrative support as key requirements. The results of the National Paediatric Diabetes Audit Patient and Parent Experience Measures survey from 2015/16 indicated that psychology input had not yet been implemented.
- There was no dedicated palliative care service for children and young people. If a patient required end of life care they were typically transferred to a specialist hospital or hospice using an ad-hoc multidisciplinary pathway. However, staff had completed consultation work with a local hospice and community nurses and a paediatric end of life care pathway had been ratified shortly before our inspection. This would enable staff to provide care and treatment in the hospital, without the need for a transfer. Until this was fully implemented, a hospital bereavement team provided advice and guidance to clinical teams and considered each patient individually to ensure the most appropriate action was taken.
- Staff in inpatient areas used a quality of care board to identify and display operational issues, unplanned admissions, medication needs or alerts, the latest handwashing standards audit result, the breast milk stock and any compliments or complaints received.
- The high dependency unit had invested in more up to date equipment and staff training to improve patient comfort and outcomes. This included the introduction of non-invasive high-flow oxygen equipment and the replacement of continuous positive airway pressure equipment. As a result of the training nurses had undertaken with the new equipment, the need to transfer patients with a respiratory problem was reduced. Senior clinical staff told us this meant the unit was in a good position for the upcoming 'winter pressures' period.
- A physician's assistant reviewed patient discharges from Tropical Bay and conducted telephone follow-ups under the supervision of a consultant. This member of staff was able to refer patients to the rapid assessment clinic after discharge and a consultant screened all referrals for safety.
- Between September 2015 and September 2016, 45% of specialist paediatric referrals to treatment were met within six weeks, 65% were achieved within 12 weeks and 90% were achieved within 24 weeks. Paediatric cardiology and paediatric nephrology demonstrated consistently good referral to treatment times within six weeks.
- A safety summit in August 2016 identified risks associated with a lack of paediatric anticoagulation staff and facilities. As a result a consultant had been assigned to lead paediatric anticoagulation and was planning to establish clinics. In addition an electronic system had been implemented that allowed clinical staff to monitor patients.

Competent staff

- Practice development nurses (PDNs) provided bedside support and clinical competency supervision for ward staff when they cared for patients with conditions they were unfamiliar with. For example, when a staff nurse was assigned a patient who had needs relating to diabetic care, the PDN worked with them to establish their level of understanding and competency and arranged regular supervision during the shift. This

enabled the patient to be cared for safely whilst providing the nurse with an opportunity to develop their skills and knowledge. The paediatric learning disability nurse worked with PDNs to provide specialised training in communication, information sharing and the care of patients with autism and learning disabilities.

- All nursing staff in the neonatal unit had up to date infant feeding competencies and a PDN assessed these on a regular basis.
- All staff received annual specialist training on child sepsis guidelines and treatment protocols.
- Nurses with special interests in certain areas could establish a link role, such as in infection control or diabetes. This meant they undertook extra training in that area, attended multidisciplinary meetings in the hospital and ensured colleagues were up to date with the latest policies and practice guidelines.
- The paediatric learning disability nurse provided training as part of the nurse and healthcare assistant induction programme, including autism awareness. Staff had access to national case studies during the training to help apply theory into practice.
- There was a dedicated programme of development in place for healthcare assistants (HCAs) and at the time of our inspection 92% of the team had completed the national care certificate. This meant their standards of care and patient interaction were benchmarked by national best practice standards. HCAs recruited from outside of the UK were trained and supported using an overseas staff conversion course that helped them to apply their existing skills to NHS practice and standards. At the time of our inspection 75% of overseas HCAs had completed this course.
- All band six nurses in Tropical Bay and Tropical Lagoon were trained mentors, which enabled them to provided targeted developmental support to more junior staff. As part of the nurse development programme, band five nurses began a mentorship course after completing one successful year working in the hospital.
- An established preceptorship programme was in place. A preceptorship is a structured programme that helps newly qualified nurses to transition to specialist practice. The programme provided nurses with six study days and the support of a preceptor link in education. New nurses received the support of two preceptors on joining a ward. This followed feedback from previous new starters who wanted more support than a single preceptor had time to provide.
- Six paediatric trust grade doctors had specialist roles in areas such as oncology, endocrinology and conducting MRI scans under general anaesthesia. This meant patients had access to a range of specialist diagnostic and investigative services with the benefit of oversight by a paediatric doctor.
- Doctors in training told us they received regular practical and simulated training, including through the use of scenarios and testing of clinical decision-making. They also received instruction and supervision from emergency department doctors in resuscitation.
- All staff had undergone an appraisal in the previous 12 months. We looked at anonymised samples of three staff appraisals. In each case the individual had clear objectives for the coming 12 months along with a support structure to help them achieve this. For example, staff were supported to attend specialist training such as for the oncology pathway and pain management. Staff we spoke with told us the appraisal process was useful to help them understand their performance and set achievable goals for their development. We saw evidence of this in appraisal records, including a nurse who was supported to progress with leadership training. Staff were asked to complete a self-reflection exercise on their own performance and how they thought this had helped them to work within the trust's 'PRIDE' ethos. This was taken into consideration by appraisers, who used staff insight on their own work to help them plan their development.
- Regular agency nurses were offered the same in-house training and development opportunities as permanent staff as well as the clinical supervision of practice development nurses. We spoke with two agency staff about this who said the trust's training was vital in keeping them up to date in the service.

Multidisciplinary working

- Senior staff ensured nurse handovers included the input and assessment of multidisciplinary teams and we observed this was taken into consideration during daily care and treatment planning. For example, where a

dietician and safeguarding nurse had concerns about the ability of a child's parents to effectively manage their diabetes, they ensured nurses had the information needed to effectively monitor the patient's condition as an inpatient.

- A recruitment campaign was active for a paediatric physiotherapist and a recently appointed paediatric speech and language therapist (SaLT) was due to start work imminently. An adult SaLT therapist was able to assess and provide care for patients over 10 years of age. There was no paediatric occupational therapy available although an associate therapy had started work and would help to increase service provision.
- A paediatric dietician and paediatric pharmacists attended Tropical Lagoon ward daily. The paediatric pharmacist did not routinely join ward rounds but did on request from clinical staff.
- Multidisciplinary working was evident across children and young people's services and this worked particularly well when staff identified patients with complex needs or when patients needed the input of multiple specialists. For example, the paediatric learning disability nurse and the paediatric dietician planned care for patients with a learning disability who also received enteral feeding.
- A transitional team was available to assist with infant care in the nursery, which meant patients were cared for separately from those in the special care baby unit.
- Five specialist nurses in diabetes provided paediatric care and treatment across the hospital and an epilepsy nurse specialist had been recruited and was due to start in January 2017. Specialist nurses led four annual transition clinics, which included input from endocrinology specialists. This team led four annual transition clinics with input from endocrinology specialists and three diabetes consultants.
- Theatre recovery nurses undertook paediatric training and rotations in Tropical Lagoon and Tropical Bay to help them understand how to deliver care and treatment to children. Paediatric PDNs worked alongside them to help develop competencies and help them to focus their clinical practice in a child-friendly way and the matron for theatres was due to introduce paediatric drug calculation testing for the team.
- The child health service delivery manager and interim lead nurse had established a working relationship with colleagues in the emergency department (ED) to improve communication and flow of patients between the units. For example, paediatric nurses were offered the opportunity to work some shifts in ED and some ED nurses had completed transfer training to enable them to support the medical team when transferring sick children to Tropical Lagoon. This formed part of a broader strategy between the two departments to improve how they provided care for children together. For example, the paediatric learning disability nurse had provided communication resources to ED staff to help them communicate with young people. This member of staff also provided support in the ED to help nurses and paramedics communicate with children with complex needs as well as help to ensure their parents understand what staff were doing.
- Hospital security staff provided on-call cover for all areas. Staff we spoke with in Tropical Lagoon spoke highly of the support provided by the security team. For example, when an adolescent patient behaved violently towards staff and began damaging their room, a member of the security team attended and resolved the situation by talking with the patient. A nurse said, "The skill of the security guard was phenomenal. They sent a female member of staff because the [patient] who was very angry was also female. The security guard didn't need to use any physical intervention at all, they were very skilled at just talking and they spent a long time with the patient calming them down."
- Staff had access to 24-hour, seven day a week support from the local child and adolescent mental health service team and used care pathways specific to the needs of each patient. For example, one pathway was in place to support patients aged 12 to 18 who were admitted to a paediatric ward from the ED and patients under 12 years old were cared for using a different pathway.
- A sickle-cell nurse specialist nurse was in post on Tropical Bay and provided specialist advice anywhere in children and young people's services. This member of staff was working with nurses to increase the scope of the service to provide care to patients with sickle-cell.
- A weekly psychosocial meeting took place to identify the needs of patients with complex needs. This included

input from a wide range of staff including mental health nurses, a paediatric psychologist, social workers, paediatric consultants, a family care coordinator, an anaesthetic nurse, substance abuse workers and the child and adolescent mental health team. Other professionals could attend on request. Meetings were recorded and action plans were distributed to all staff involved with each patient's care and treatment and helped staff in multiple areas of the hospital to identify unmet patient need. For example, staff discussed children who frequently attended the emergency department to consider how this could be avoided in future.

- A charities lead for children's services was in post and liaised between non-profit organisations, play specialists and ward staff to secure new play equipment.
- Medical handovers included input from pathology and the learning disability nurses. In addition, the psychosocial needs of each child were discussed and their broader welfare considered when planning care and treatment.
- In September 2016 the hospital audited the completion of multi-agency referral forms that were used to refer children to community or social services when staff had concerns about their welfare. The audit found 100% compliance with documenting the reason for the referral and found practitioner's handwriting could delay a response from social services. As a result of the audit, more computers were provided for staff with software to enable them to complete referrals electronically and additional training was provided for all staff.

Seven-day services

- Tropical Lagoon and the neonatal unit had consultants in attendance seven days a week. Overnight a consultant was on call.
- A consultant biochemist, consultant haematologist and consultant microbiologist was available on call 24-hours, seven days a week.
- Radiology, neuro trauma radiology and pathology provided 24-hour service, seven days a week.

Access to information

- Safeguarding staff were responsible for uploading local authority child safeguarding alerts to the hospital's electronic systems. An audit of this system took place in August 2016 and indicated alerts were uploaded to patient records and hospital systems within 24 hours of receipt, including when they were received at weekends. All clinical staff had access to this information once uploaded to hospital systems. Although the audit indicated good practice, the safeguarding children's operational group implemented an additional daily check of the e-mail system to reduce the time it took to add information to the electronic system.
- Staff used a colour-coded system to indicate in patient records when they had a safeguarding alert or child protection order in place. They could access more detailed information about this in the hospital's electronic systems.
- The trust had invested in more IT equipment and as a result staff had faster and more reliable access to policies, protocols and patient communications between services.
- Posters were displayed in nurse stations that detailed care pathways and treatment protocols, including for sepsis, accessing specialist clinical support and escalation procedures.

Consent

- Shift leaders used daily handovers to remind staff that consent forms must be completed and kept in nursing paperwork. This included empowering nurses to challenge doctors who had not completed consent forms or when patients arrived from surgery or another department without consent documentation.
- An audit of patient records in July 2016 highlighted the need to improve consent documentation processes, particularly when a child was admitted from another service or department.

Are services for children and young people caring?

Good

We rated caring as good because:

Services for children and young people

- Feedback from the trust's 'I want great care' initiative indicated most people were happy with the care received and would recommend the service. Staff had adapted this survey to make it more accessible to children and young people, so they could give their own feedback.
- Staff spoke to people with kindness and respect and modified their communication to meet the needs of people they were talking to. Parents reported consistently good experiences when interacting with staff and provided only positive feedback about everyone they spoke with in the hospital.
- The hospital participated in the National Paediatric Diabetes Audit Patient and Parent Experience Measures survey. The results indicated patients and their parents felt communication from clinical staff was good and they felt involved in care planning and delivery.
- Staff demonstrated an understanding of the needs of patients in the way they worked and delivered services. For example, paediatric phlebotomists used distraction techniques and a reward system to reduce anxiety around blood tests. We also saw play specialists working with children in a way that clearly distracted them and reduced their anxiety about being in hospital.
- The safeguarding children's assurance group evaluated the feelings of children and young people with a learning disability and their parents and used the results to improve the service.
- Emotional support, including bereavement services, was readily available to patients and their parents. This included through a multi-faith chaplaincy service and support from nurses.

Compassionate care

- We spoke with five parents of infants who received care and treatment in the neonatal intensive care unit. All were positive above the care their child had received. One parent said, "Staff are clearly in control of the situation and I'm reassured by their confidence." Another parent said, "I'm delighted with the approach of the whole care team, they've been very responsive to everything we've needed." The parents of seven children cared for on Tropical Lagoon described the care provided by nurses as "tremendous" and "amazing." One parent said, "Staff are tremendously caring and kind."
- Children and young people's services participated in the 'I want great care' programme. This was a patient and relative's survey that asked questions about the quality of care and how they felt about the service. This information was compared with each ward across the trust and the results displayed on the ward. The latest information on display in Tropical Lagoon was from August 2016 and indicated that 95% of 149 respondents would recommend the service and 94% gave the unit a maximum five star rating. In the same period, 86% of 193 respondents would recommend the service provided on Tropical Bay. Staff had produced a version of the questionnaire suitable for children, using pictures to help them understand how to answer questions such as 'Were the people looking after you kind?'
- Paediatric phlebotomists offered children a bravery present after taking their blood. Children knew about this in advance and it helped to calm their anxiety about having blood taken.
- The trust used a 'You're welcome' survey to obtain feedback and experiences from patients and their relatives. This had recently been updated to include a question about whether respondents felt the trust was a friendly and welcoming place for young people.
- All staff demonstrated kind and compassionate behaviour, including in subtle approaches to helping people when they were stressed or anxious. For example, we saw a member of staff proactively offer the use of a landline telephone when a relative was becoming more frustrated at not being able to get a signal on their mobile phone.

Understanding and involvement of patients and those close to them

- We observed nurses introduced themselves to patients and relatives at the beginning of each shift. This was done with a friendly, informal manner and contributed to reducing anxiety and providing reassurance.
- A 'quality of care' information board at the entrance to paediatric outpatients displayed a message that stated, "Lots of compliments received about paediatric

phlebotomy." The board also stated staff had received compliments about, "special needs children up to 18 years old." It was not clear who this comment referred to.

- Paediatric phlebotomists provided a colourful visual display to help parents prepare their child for having a blood test. This included photographs of staff undertaking the procedure and advice about how to explain the procedure to children. Staff had prepared this based on their understanding of the anxiety blood tests could cause and included advice such as how to communicate calmly with children through effective speech and support.
- The paediatric learning disability nurse worked with children and their parents in an advocacy capacity. For example, if a child with a learning disability or other complex needs was booked into the outpatients department, the nurse liaised with the consultant to ensure times were coordinated so the child did not need to wait in the waiting room. This helped to ensure all staff understood the needs of patients who would become anxious or distressed in waiting areas.
- We observed a play specialist proactively engage with children in the paediatric outpatients waiting area in a way that involved them and made them feel welcome.
- As part of the National Paediatric Diabetes Audit, the hospital participated in the Patient and Parent Experience Measures survey to benchmark patient and parent feedback against other units. The hospital demonstrated a significant improvement in how people responded to a question that asked if they had been given time to ask questions about diabetes care. In 2015/16 100% of patients agreed with this, which was better than the London and national average.
- In September 2015 the safeguarding children's assurance group investigated the results of surveys given to patients aged between six and 17 years old when they left hospital to ask about their experience of being involved in their care. The results showed improvements from previous years, including 88% of respondents reporting they felt the information given to them was useful and understandable. In addition, 84% said they felt they had been given information about their tests and results. Young people stated they wanted more input into who examined them and when, which the assurance group shared with clinical staff. Between June 2016 and August 2016, the learning disabilities nurse adapted this audit for children with a learning disability to help understand how children who found expressing themselves difficult felt in children's services. This audit was conducted with 10 children and results were positive. For example, nine out of the 10 respondents said staff explained their care to them in a way they could understand and that they felt staff listened to them. Nine out of ten children said that nurses and doctors spoke directly to them and six out of ten said staff explained treatment in a way they could understand.

Emotional support

- Nurses demonstrated an awareness of the anxiety and stress of the carers and relatives of children. For example, during a nurse handover one nurse noted that a parent had been increasingly anxious overnight and discussed with colleagues taking over the shift how they could continue to support them.
- Bereavement boxes were available on the unit and the hospital multi-faith chaplaincy was able to work with nurses to prepare these for parents. A bereavement box is used for parents to take keepsake items away from the hospital to assist the grieving process, such as a lock of hair or an item of clothing.
- A children's non-profit organisation funded a weekly visit from a clown for Tropical Lagoon ward. This character entertained children and provided them with significant positive emotional support and distraction from the clinical environment.
- Staff used a weekly multidisciplinary meeting to ensure appropriate care was provided for children with complex emotional needs and those in need of support in relation to domestic violence.
- Parents we spoke with told us they felt staff had an understanding of their emotional needs. For example, one parent said a nurse spent time speaking to them when they were scared and stressed and another parent said nurses had "gone out of their way" to make them feel welcome when they were anxious about being a long way from home.

Services for children and young people

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Parents were able to stay overnight in the hospital and staff provided blankets and pillows in sleeping areas.
- Facilities for breast feeding were available throughout the hospital and the neonatal intensive care unit was equipped with breast milk fridges and freezers. Each new mother was given a breast expressing kit and staff were knowledgeable in health promotion to help mothers choose the most appropriate form of feeding for them.
- Paediatric phlebotomy services were in place to enable blood to be taken from children by staff trained to recognise needle phobia and to use distraction techniques. An increase in staffing in this team meant the waiting time for blood tests was typically one day or less.
- A peripatetic local authority school teacher was assigned to children and young people's services on a weekly basis to ensure children receiving treatment for cancer or under the care of haematology received educational support.
- The paediatric diabetes team ensured someone was available by phone, e-mail or text every day and patients or their parents could contact them for advice or support.
- Staff had worked to improve communication between children and young people' services and the emergency department (ED). For example, the nurse in charge in ED called Tropical Lagoon at the beginning of each shift to plan emergency admissions.
- Tropical Bay ward could be opened and staffed out of hours to assist in managing surgery lists. Other strategies to reduce waiting times were introduced, including referring patients to a 'hot clinic' for rapid assessment and using daily multidisciplinary coordination meetings to plan safe discharges.
- GPs had direct telephone access to a paediatric consultant. This enabled hospital staff to triage patients in advance and direct them to the rapid assessment clinic or to the main emergency department.
- Outpatient clinics offered extended hours at weekends to help reduce the waiting time for referred patients and an additional phlebotomist had been recruited and reduced the waiting time for blood tests to one day. An escalation plan was in place for when units reached full capacity and daily multidisciplinary team meetings took place to plan for admissions and discharges.
- Play specialists were available and they provided children with a range of activities. Tropical Lagoon and Tropical Bay were decorated with the artwork of children who had stayed on the units and there were three well-equipped play areas available, including a covered outdoor play area with direct access from Tropical Lagoon.
- A sensory room and mobile sensory equipment was available to help support children and young people with sensory needs, learning disabilities or needs relating to autism. Staff facilitated the use of this equipment whenever it would benefit patients, including access to the sensory room for a child who was undergoing a blood transfusion.
- A dedicated paediatric learning disabilities nurse had developed a hospital passport for children and visual communication aids. This helped staff to communicate with patients and to understand their likes, dislikes and worries. Parents and staff spoke highly of the passport, which had bene evaluated to identify areas for improvement.
- Transition services were in place for children moving into adult services. This included support to gradually build their independence and one-to-one support as they were moved onto an adult pathway.

However:

- Children and young people who needed a blood test were sometimes seen in adult outpatient phlebotomy. In this area, staff were not able to use child-friendly equipment for blood tests.

- Neonatal services did not have a repatriation policy in place. This meant there was no established pathway to safely transfer patients from the hospital to another hospital or treatment facility near their own home.
- The neonatal intensive care unit did not have a repatriation policy or a transition pathway for infants with low blood sugar, nasogastric tubes or those on a drug withdrawal pathway. This meant infants could be cared for on the NICU for longer than needed, which could delay admissions.

Service planning and delivery to meet the needs of local people

- Each patient bedside in Tropical Lagoon had a chair that converted into a bed for a relative to be able to spend the night. Staff provided sheets, blankets and pillows. Six relatives told us this was an improvement on their previous experiences and said it helped them to sleep well whilst next to their child.
- Senior staff controlled access to the neonatal unit for safety, security and infection control purposes and only siblings over the age of 12 were able to visit the unit. A senior community nurse facilitated a weekly patient support group in the neonatal unit (NICU).
- The NICU was equipped with breast milk fridges and freezers and staff gave each new mother a breast expressing kit. Although staff encouraged breast feeding, they did not insist on this and a stock of formula was always available. A private room was available for expressing milk and each mother was able to take a hand pump home with them. A baby feeding room was available in the main foyer at the hospital entrance as part of an overall culture of supporting mothers to be able to feed their infants when on site.
- Recent improvements in the paediatric phlebotomy service were due to be introduced to the trust's other hospital to improve choice of service for local people. For example, a walk-in paediatric service was able to see children aged up to 12. This service was provided in the paediatric outpatients department. However, when the service was very busy or children aged over 12 needed to be seen, they attended the adult phlebotomy service. This meant children could wait in an adult waiting area for up to two hours to have blood taken. Phlebotomy staff showed us there was a two tier process in place for collecting blood. For example, in paediatric outpatients, phlebotomists could take blood using the 'butterfly' system, which is more appropriate for children. In adult phlebotomy, staff told us they were trained to use this system but senior staff told them not to. We were not able to identify the reason for this.
- Staff had completed a scoping exercise to make their uniforms more recognisable and 'child friendly'. This involved piloting designs and colours with the staff team and seeking feedback from children and relatives. The new uniforms were due to be introduced imminently and would enable paediatric nurses to be readily identifiable across the hospital.
- A peripatetic local authority school teacher was assigned to children and young people's services on a weekly basis to ensure children receiving treatment for cancer or under the care of haematology received educational support. We spoke with the teacher who said their weekly presence was assessed on the length of stay of patients. This meant if children were admitted on a long-term service they were able to visit more often. This individual maintained a record of children who visited the hospital often for long term condition treatment and ensured they brought their school work in with them.
- Clinical staff provided training to parents on the use of specific equipment, such as nasogastric tube feeds, when their child was due to be discharged.
- A consultant led a paediatric oncology shared care unit in Tropical Bay that enabled patients to receive intravenous fluids within one hour of arrival and to be treated for febrile neutropenia.
- Paediatric outpatient nurses were able to provide care and treatment in cases that did not require sedation and two orthodontic rooms were also available.
- Parents and carers of children in Tropical Lagoon were offered free parking at the hospital.
- The paediatric diabetes team were available by phone, e-mail and text message and results from the National Paediatric Diabetes Audit Patient and Parent Experience Measures survey indicated 100% of young people and their parents were happy with the responsiveness of this team. This indicated significantly better performance than comparable London and national units.

- In response to long waiting times for phlebotomy appointments, a second paediatric phlebotomist had been recruited. As a result, waiting times reduced from three weeks to one day. The additional capacity meant the paediatric phlebotomy service could see patients up to 12 years of age, which reduced the need for children to be seen in the adult phlebotomy area. Young people with a learning disability could be seen up to 18 years of age. During busy times, the adult phlebotomy unit could see patients aged three and above.

Access and flow

- Patients aged 16 years or younger were admitted or treated using a paediatric or young person's pathway. Patients over the age of 16 years were cared for on an adult pathway unless there were additional considerations, such as a learning disability. At the time of our inspection this process was under review.
- Referral to treatment times (RTT) were consistently good across specialist outpatient services. No patients who waited 52 weeks or more for treatment between July 2015 and July 2016.
- As the result of a plan to improve communication between Tropical Lagoon and the emergency department (ED), the ED nurse in charge contacted the ward at the beginning of each shift to check bed availability and coordinate any planned or emergency admissions.
- Neonatal services did not have a repatriation policy in place. This meant there was no established pathway to safely transfer patients from the hospital to another hospital or treatment facility near their own home. In addition, there were no transition services in place. This meant infants with low blood sugar, nasogastric tubes or those on a drug withdrawal pathway were cared for longer than necessary in the NICU, which could delay other admissions.
- Tropical Bay ward could be opened and staffed out of hours to assist in managing surgery lists. For example, during our weekend unannounced inspection this unit was open with 12 bays in use for urology and ear, nose and throat patients. The unit provided care for patients undergoing elective procedures planned in advance, which enabled the hospital to reduce waiting times and ensure a safe level of staffing.
- During our weekend unannounced inspection a consultant-led children's dermatology outpatient clinic was open, with 24 appointment slots filled. This was an ad-hoc response to try to reduce the waiting list for patients and to help work towards achieving the national indicator of 18 week maximum wait from referral to treatment.
- Staff were responsive to the configuration of Tropical Lagoon ward when patients were admitted with specific risks. For example, during our inspection two babies with the same infection were admitted and staff cared for them using a 'cohort' system. This meant staff cared for both patients in the same bay to reduce the risk of cross-infection with other patients.
- Staff kept patients up to date with delays in outpatient clinics using a display board. On one day of our inspection, three outpatient clinics were all delayed, with an average wait of 80 minutes.
- GPs had direct telephone access to a paediatric consultant. This enabled hospital staff to triage patients in advance and direct them to the rapid assessment clinic or to the main emergency department.
- A consultant-led 'hot clinic' operated out of paediatric outpatients. This was a GP referral clinic for children who were not poorly enough to be seen in the emergency department. This service meant children could be assessed rapidly without putting additional pressure on other hospital services.
- Between September 2015 and September 2016, an average of 20% of new patients in the outpatients department did not attend booked appointments. In the same period, an average of 30% of patients did not attend a follow-up appointment. There was an up to date policy to help staff take appropriate safeguarding action in the event a patient did not attend a booked appointment. This included appropriate follow up with a parent and the involvement of other services if the child was under a protection order.
- A contingency plan was in place in the event the NICU reached full capacity. This included planning between the unit coordinator and other hospital services, including escalation to the site team. One emergency cot was always available and patients could be treated safely in Tropical Lagoon or the postnatal ward as part of the plan.

- Daily multidisciplinary coordination meetings took place with staff from children and young people's services and from maternity to identify issues with capacity and discharge. Staff used this meeting to predict any problems with capacity later in the day and ensure a strategy was in place to avoid a negative impact on admissions or discharges.

Meeting people's individual needs

- The NICU had two private rooms for families and a separate room for mothers to express milk. This unit had on-site laundry facilities.
- Parents with a baby in the NICU were able to stay overnight and the unit had two en-suite bedrooms for their use. There was no catering provision for parents in the unit but they could bring their own food and catering services were available elsewhere in the hospital.
- A specialist learning disability nurse was available and supported annual transition clinics as well as being available for paediatric support anywhere in the hospital.
- Each unit or ward displayed live staffing information at the entrance. This meant parents and visitors could easily identify the nurse in charge of the shift. There was also a colourful information board that helped people to identify the role of each member of staff based on their uniform colour. This meant they could easily identify senior staff, nurses and support staff.
- Staff used information display boards on Tropical Lagoon ward to provide a range of information to parents and visitors. This included information on how to ask for help with language needs and how to access other services such as chaplaincy or the patient advice and liaison service.
- Two play specialists and two play workers provided support to children on Tropical Lagoon, Tropical Bay and paediatric outpatients Monday to Friday between 7.30am and 4pm. The play specialists maintained a stock of play equipment that enabled children to paint, create artwork and engage in stimulating activities that helped keep them active and distract them from the clinical environment. The unit was decorated in pictures and drawings children had created and contributed to a bright and colourful environment. Feedback from children was posted in display areas and included comments about how they had enjoyed their time in the ward and the types of activities they had taken part in. One child had said, "I took my painting home, which made me feel very proud." The play specialists renewed the environment with the help of patients to reflect the season, which also formed part of the educational aspect of their role. Although play staff were not available overnight or at weekends, children could use play areas and equipment at any time and nurses were trained to safely supervise this.
- Tropical Bay and Tropical Lagoon had play areas with toys and equipment were available for a range of ages and Tropical Lagoon had a secure outdoor play area with park equipment for young children. This area had padded flooring to protect children if they fell or tripped.
- Tropical Lagoon and Tropical Bay wards did not have any permanent male nurses, healthcare assistants or play specialists. Senior staff acknowledged this meant male patients, particularly adolescents, did not have access to male staff for personal care or for social interaction. Some contingency provision was available to provide male staff. For example, a male play specialist was available at another hospital in the trust and could be assigned to Tropical Lagoon if needed. In addition, staff had access to a male mental health nurse and a male healthcare assistant in ED had been trained to support transfers to Tropical Lagoon.
- An adolescent information stand was available at the entrance to paediatric outpatients. However, printed information was limited and only leaflets on organ donation and HIV were available and the information provided was not tailored to this age group.
- A sensory room was available on Tropical Lagoon ward that provided children with an interactive environment that was calming and meditative. This was particularly useful for young people with epilepsy, autism or other conditions that made staying in a hospital ward particularly stressful. Staff were able to support patients with complex needs to access this room and had previously conducted risk assessments and a plan to enable a patient undergoing a blood transfusion to access the sensory room.
- The paediatric learning disability nurse had introduced a number of initiatives to support patients with a

learning disability. This included a children's hospital passport. Based on the adult version commonly used to help staff support patients with dementia, this version was adapted to include details of other health professionals involved in their care, such as school nurses and health visitors. It also included a communication and information sharing tool to ensure staff were able to involve patients in discussions about them by adapting the way they spoke. This tool included a section that parents could complete with children about their likes and dislikes. We asked staff about this who told us it helped them to establish a rapport with children before giving care or treatment. For example, a doctor said they used the hospital passport to find out the favourite football team of a child who found it difficult to communicate. This built a relationship between them and enabled the doctor to proceed with treatment that otherwise would have caused anxiety for the child. The hospital passport included details of sensory sensitivities; such as if the child disliked certain noises or would become anxious if too many people were near them. The passport was printed in easy-read format with pictures to help children understand procedures using photographs. For example, one section was titled 'What will happen during my blood test?' and included step by step photographs of how this procedure worked. As part of this project the nurse had produced a series of picture cards to help staff communicate with patients who could not speak. This enabled patients to point to images that represented what they wanted to do such as go to bed or read a book.

- The hospital passport had received positive feedback from staff and parents who used it and the learning disability nurse was developing an electronic version. This would enable parents and their children to update this whenever they wanted and share it easily with hospital staff ahead of an admission. We looked at two passports that were in use at the time of our inspection. Parents showed us how their children had helped them to complete it and said they felt it helped staff get to know their child. All of the nursing staff we spoke with had a good understanding of the passport, including agency nurses.
- Staff worked with children with complex needs who moved from child services into adult services to ensure the period of transition was structured and supported them. This included up to five years of ongoing support between the ages of 14 and 19 that gradually trialled giving individuals more independence then increased this to increase their confidence and ending with a reflection of their time in child and young people's services. Paediatric staff ensured this reflection was shared with colleagues in adult services who would continue to provide care. This helped to ensure patients received continuity of care because staff took time to understand their needs and goals. Some adult wards had sofa chairs in them and paediatric staff aimed to ensure young people transitioning between services were admitted in these areas so that a parent could stay overnight at their bedside.
- Staff used a butterfly sticker on side room doors to discreetly indicate when a patient was receiving palliative care. This prompted staff to be quiet in the area and to be aware that this would be a distressing time for relatives.
- Staff collected data on delayed clinics in paediatric outpatients and displayed this for patients. In the month leading to our inspection, 15% of clinics had been delayed.
- Tropical Bay had headsets available for young people who could experience sensory overload if they had to wait in the waiting room for their appointment. This enabled them to listen to music that helped to reduce their anxiety or distress.
- Staff displayed information about common health concerns targeted at adolescents on Tropical Bay. This included signposting to health services available to them, such as their local GP and 111 service. The board included information about managing health and wellbeing concerns that staff said they saw regularly in the unit, including minor dermatology concerns such as acne, managing stress and hangovers.
- There was a consistent focus on ensuring patients individual needs were met from all staff in paediatric services, including evidence of significant extra effort when needed. For example, when a patient was transferred out of hours from a hospital several miles away to Tropical Lagoon, staff on the ward noted the

original hospital had not sent the patient's medicine. To rectify the situation, the on-call pharmacist drove to the other hospital, collected the medicine and delivered it to staff looking after the patient.

- A specialist children's non-profit agency had provided distraction toys for children. Staff used the toys during procedures to help divert children's' attention and reduce anxiety and distress.
- Printed information was available in Tropical Lagoon to help parents understand care and treatment options and processes, including in children with cancer and children with disabilities.
- The paediatric phlebotomy service was available Monday to Friday from 8.30am to 5.50pm. Paediatric phlebotomy rooms had sensory ceilings with fibre optic lights, which helped to calm and distract children with sensory conditions while staff took blood. This service also had interactive toys and books to help distract children and music available to help children with a needle phobia.
- In July 2016 the safeguarding children's operational group published an audit of the ability of phlebotomy services to meet the needs of children with a learning disability or similar complex needs. The audit took place between October 2015 and February 2016 and found good practice, with no failures to take blood as a result of a child's perception of the procedure. The audit included positive comments from the parents of children and recommended that the learning disabilities nurse provide training in how to effectively de-sensitise children to the procedure. During our inspection we found this had been successfully implemented.
- Adolescent sexual health services were available on site two evenings per week. Patients could refer themselves or paediatric staff were able to assist them in accessing the clinics.
- Other considerations to meet individual needs were provided. For example, staff could book interpreters for meetings with parents and children who did not speak English, advocacy services were available and culturally appropriate food could be ordered.
- Adolescents had access to sexual health services including a young person's sexual health nurse and a nearby sexual health clinic. Staff could visit patients in the hospital or could provide a direct referral appointment to the clinic.

Learning from complaints and concerns

- The complaints procedure was readily available in printed format in clinical areas as well as guidance for accessing the Patient Advice and Liaison Service.
- The matron or lead nurse in each area took overall responsibility for responding to and investigating complaints. Where a complaint related to the actions of a member of staff, the nurse in charge of the shift in question would support this process.
- Parents and relatives regularly sent thank you cards to staff in paediatric services, which were displayed in public areas. For example, parents used a card in the neonatal unit to praise staff for their kindness and dedication when their baby's decision deteriorated.
- Staff in paediatric outpatients ensured the waiting times for clinics were displayed in the main waiting room and updated whenever this changed. This was in response to previous complaints from parents.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- An improvement and development plan was in place, which included the expansion of neonatal services and on going recruitment to fill nurse vacancies. A new end of life care strategy had also been ratified that would enable staff to work with local hospices and multidisciplinary community teams to provide dedicated palliative care.
- Risks to services were monitored by a quality and safety committee with clinical and non-clinical representation from each service. In addition the division held a risk register that identified significant risks to the service and was used to track improvements.

- A new divisional lead nurse was due to start work in early January 2017 and would continue to develop service improvements. An interim lead nurse had begun to prepare for this by building care pathways between services in the hospital and planning to improve information sharing between different areas so that young patients could more easily be identified.
- Staff were offered opportunities to develop their leadership skills as part of a development pathway and as a trust strategy to reduce turnover.
- Staff told us this was a good place to work and they enjoyed the challenges and opportunities for development. Most staff said they knew who they could speak to if they needed help or to raise issues and concerns confidentially.
- Quality and safety staff held a weekly patient safety summit with patient representatives. This group included adolescent representation and was representative of the embedded approach to involving people in the running of services. For example, several areas had been decorated or refurbished by the parents of children who had been cared for in the hospital and resources such as mobile sensory equipment had been donated by non-profit organisations.
- Staff at all levels were able to be involved in the trust's improvement plans. This included staff identifying work that needed to be completed in their department or ward and acknowledging achievements. Following staff changes in one ward, senior staff had met each member of staff individually to discuss their feelings and find out how they could be supported.
- There was evidence staff could confidently provide feedback to the senior team and that changes were considered and implemented where possible. For example, a new long day working pattern was introduced in one ward following feedback from staff.
- Staff engaged in research and pilot schemes to drive a culture of change to improve practice and deliver a high standard of patient care.

However:

- Although senior divisional staff had a good understanding of the risks to their respective services as recorded on the risk register; staff responsible for the immediate delivery of clinical care were not always aware of the recorded risks for their service.

Leadership of service

- A paediatric matron normally led children and young people's services. This individual was acting as the interim lead nurse until January 2017 when a new divisional nurse was due to commence their post. To support senior nurses in paediatric areas in the absence of the matron post, two practice development nurses undertook senior paediatric coordinator roles and reported to the interim lead nurse and the paediatric general manager. A child health service delivery manager led paediatric services, including the NICU and had begun to plan the scope of the new divisional nurse post by working with lead staff in each specialty service. For example, a key role of the new member of staff would be to establish a better system for monitoring paediatric patients wherever they were cared for in the hospital. This would enable better oversight of the children and young people's services as staff did not have access to a single system they could use to identify and locate children outside of paediatric services.
- The trust's improvement programme included the introduction of a leadership development pathway to support nurses in progression towards a senior role. We spoke with staff nurses about this who told us they felt the senior team recognised and rewarded talent and more senior nurses were supported to lead shifts as part of their development.
- Whole-team meetings took place monthly on Tropical Bay and Tropical Lagoon. The minutes and outcomes of meetings were e-mailed to all staff afterwards and nurses told us they fell up to date and well-informed by the process.

Vision and strategy for this service

- In response to our previous inspection findings at this hospital, the trust implemented an improvement plan that included working with staff to improve engagement and communication between senior management and

staff teams working on the wards and in clinical areas. This was an overall trust plan with a number of clear objectives and staff in each service area demonstrated an understanding of how this applied to their ward.

- Staff in the neonatal unit (NICU) told us a transition ward had been planned for the past four or five years but they had not seen any progress. The division recognised the NICU as an area of risk due to capacity and a plan was in place for development and expansion.
- The paediatric learning disability nurse had significantly improved resources and training for patients with complex needs as part of a new post. They planned to continue developing services for patients transitioning between paediatric services and adult services and introduce a transition clinic in which young people and their parents could meet with the nurses they were used to in paediatrics together with nurses from the adult service that would be providing care going forward. This would be an extension of the current system in place and would further reduce the anxieties and worries that staff knew young people experienced when moving services.
- The clinical lead for specialist palliative care and the end of life care committee led the production of an end of life care strategy for 2016 – 2021. This was based on national end of life care audits, the national palliative care framework and on views from staff, patients and carers. The trust board ratified the strategy in November 2016 and this would enable the end of life care team to significantly improve services for children and young people in the hospital and in the community through improved partnership working with local hospices.

Governance, risk management and quality measurement

- Services for children and young people were within the women's and child health division, which was led by a divisional director and lead nurses and matrons for each individual service.
- Divisional staff held a multidisciplinary serious incident meeting twice weekly. A quality and safety officer attended this and could recommend that incidents were escalated to serious incident level and also that serious incidents could be deescalated if necessary. In addition, a monthly multidisciplinary quality and safety meeting was used to review incidents, complaints and events in the service.
- We looked at a sample of quality and safety group meeting minutes. These were attended by staff from each paediatric area as well as the children' quality and safety advisor and interim lead nurse. There were clear actions from the meetings, including plans for nurse education and training and a review of incidents.
- Senior staff used a risk register to monitor risks to the service and to ensure work to resolve them was timely and appropriate. At the time of our inspection, paediatric services had seven active risks on their register. There was evidence staff regularly reviewed risks and at least every three months there was a documented update to the status of the risk. However, it was not always clear how well risks that involved multiple services were managed. For example, one risk from May 2016 referred to the inability to provide cranial ultrasound and echocardiogram images due to a lack of electronic storage facilities in the scan machine in neonatal ICU and paediatrics. The risk included a potential loss of data and images if scan data were transferred with a patient to another hospital. The member of staff responsible for this risk had documented contact with the imaging manager and patient records system manager in May 2016 but an entry in August 2016 indicated no further contact or progress had been made. This meant there were not established communication processes in place that enabled staff with the responsibility of managing significant risks to explore and implement resolutions. In addition, senior ward-based staff were not aware of the risk register for their service. This meant although senior divisional staff had a good understanding of the risks to their respective services; staff responsible for the immediate delivery of clinical care did not.
- A shortage of nurses was a key risk of the service. To address this, a continuous programme of nurse recruitment was in place and clinical staff had developed a pathway to support healthcare assistants with appropriate clinical skills to begin nurse training. At the time of our inspection, 18 healthcare assistants had successfully accessed this and started their training.

Senior staff we spoke with were positive about this programme and said it was a useful strategy to address the hospital's short staffing problems by developing existing members of the team.

- The trust's human resources team conducted an annual audit of the safety processes in place for all staff recruited to the hospital, including to services for children and young people. This involved a check that staff were recruited in accordance with the NHS Employment Check Standards and had a clear Disclosure and Barring Service background check. The latest audit from July 2016 indicated 100% compliance with this in children's services.

Culture within the service

- Staff we spoke with described the hospital executive team as "visible and approachable" and said they were good at sharing information with everyone across the trust. A member of staff who had moved into a new role in the previous 12 months said, "[The executive team] is pushing to progress my career, development and learning. It's clear they have a keen interest in my work and have they tell me when I'm doing well." Another nurse said, "The head nurse comes onto the ward often, she is a familiar face here."
- Each service area operated a 'star of the month' staff award. This enabled individuals to nominate a member of staff who had made a significant contribution in the ward or unit, which the trust recognised with an award, certificate and a gift. Staff we spoke with were positive about this and told us they felt involved in it as a way to acknowledge the work of each other. This included colleagues who reported into other services or divisions but who regularly worked in one ward or area, such as pharmacists. In addition to the star of the month programme, HCAs who completed the care certificate were recognised with an award ceremony.
- Tropical Lagoon ward displayed their equality statement at the entrance to the unit. This advised staff and patients that care and treatment was provided without prejudice to any individual characteristics including age, disability, race, sex, sexual identity, religion or belief, gender identity, marital or civil partnership status or pregnancy and maternity status.
- Young people and their parents under the care of the paediatric diabetes team were asked if their cultural or religious beliefs were respected as part of the National Paediatric Diabetes Audit Patient and Parent Experience Measures survey. The latest results for 2016 indicated 100% of respondents agreed with this statement.

Public engagement

- Parents and relatives of patients previously cared for on Tropical Lagoon had contributed to the development and resources of the ward. For example, a parent's room had been furnished and refurbished following a successful fundraising drive and a well-equipped sensory room resulted from engagement between a parent and hospital staff. A children's non-profit organisation had provided mobile trolleys with sensory equipment. This enabled staff to use the equipment with children wherever they were in the ward without the need to take them to the sensory room. This also meant staff could use the equipment to help calm and distract patients during procedures.
- Staff demonstrated awareness of the need to engage with visitors and relatives in a way that respected them and kept patients safe from avoidable harm. For example, one nurse spent time discussing the unit's access policy with a group of young family members who wanted to see a child on Tropical Lagoon. The nurse was concerned about the size of the group and the noise they created on entry. To ensure the group did not cause any distress to patients in quiet areas, a nurse took them to a non-clinical area and explained the nature of what was happening on the ward and how they were expected to conduct themselves. In another instance, a parent had been verbally abusive to a nurse. In response a doctor and the senior sister met with the parent to explain their expectations of behaviour towards staff and to find out if there was any support they could provide that was not being received. In both situation staff were able to reassure the individuals concerned and ensure patients and staff on the ward were treated with respect.
- Volunteers on Tropical Lagoon ward encouraged parents to complete surveys as part of a drive to maximise the response rate. This would enable staff to build a more robust understanding of trends and commonalities in feedback.

- Quality and safety staff held a weekly patient safety summit with patient representatives. This group included adolescent representation and items reported were taken forward to be discussed at monthly quality and safety meetings and monthly divisional meetings.

Staff engagement

- The trust's executive team had involved staff in all roles and at all levels of responsibility in the hospital in the development and implementation of its improvement plan. This included regular checks on how individual departments identified the improvements they had achieved and those they aspired to. Staff could contribute to the tracking of improvements plans by displaying comments on 'How we've improved' posters displayed in staff rooms and meeting rooms. The posters enabled staff to identify achievements in the previous three months and list their plans for the next three months. Staff in Tropical Lagoon identified an improved control of substances hazardous to health record and improved incident reporting as key achievements in the previous three months and implementing improved safer needle systems and improving staffing levels as upcoming priorities. Staff in the NICU commented that medication administration and staffing levels were recent improvements and listed an increase in cot capacity and improvements in neonatal data analysis unit compliance as their next goals.
- Staff were able to give feedback on their area of work to their line manager, during team meetings or through a staff survey. For example, following feedback from staff, a new long day shift was introduced on Tropical Lagoon ward.
- There had been an unexpected change in staffing at ward manager level in Tropical Lagoon. In response, divisional managers contacted individual meetings with each member of ward staff and asked about their welfare and wellbeing as well as what they would like to see changed to feel more supported.

Innovation, improvement and sustainability

- A business case had been approved for the provision of an additional seven cots in the special care baby unit. This would significantly reduce pressure on the service.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which significantly improved the quality of life for families.
- A NICU research nurse had led a blind study on the effective use of lung lines (PREVAIL). This was representative of an overall drive to use research and pilot schemes to drive improvements in the service.
- Local school children had visited Tropical Lagoon to raise awareness of public health issues amongst children and young people cared for on the unit.
- Staff in Tropical Lagoon worked with ear, nose and throat (ENT) colleagues to pilot a scheme of earlier pre-discharge reviews for children. This was to reduce the risk children would miss a day of school due to discharge delays awaiting an ENT review. The pilot was in its infancy and not all ENT staff were able to conduct early reviews but nurses told this had been a positive initiative that worked well for children.

Outpatients and diagnostic imaging

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

Information about the service

Queens Hospital offers a range of services and clinics for outpatients, including: anaemia, cardiac rehab, ophthalmology, dermatology, anti-coagulation and deep vein thrombosis (DVT), dermatology, clinical oncology, and four general outpatient teams, as well as a sexual health outpatient's team.

The outpatients department organises all outpatients' clinics. The department provided 817,013 outpatient appointments between March 2015 and March 2016 across two sites.

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

During the visit we spoke with over 20 staff on the wards. These included a clinical leads; a matron; senior managers; nurses; physiotherapists; health care assistants; phlebotomists; and a range of diagnostic and imaging staff including: radiologists, administration staff, radiographers and patients.

We talked with eight patients who use services. We observed how patients were being cared for and talked with four carers and/or family members and reviewed patients care or treatment records.

We also reviewed the systems and management of services including quality and performance information.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging services as good because:

- There was evidence of significant 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 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.

However , we also found:

- 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.
- We found alcohol hand sanitising gel dispensers in the ground floor outpatients waiting area and diagnostic and imaging department entrance were empty. Staff in the diagnostic and imaging department did not observe best practice guidance on hand washing or using sanitising gel between patients. The first floor outpatients' department corridor was being used as a waiting area and this created a risk due to patients waiting in the corridor.

Outpatients and diagnostic imaging

- Privacy curtains were not being drawn in the main diagnostic and imaging department, and the emergency room in ophthalmology had bays that did not promote patients' privacy and dignity. Phlebotomy waiting rooms were full and there appeared to be limited space for the phlebotomy service's footprint to expand.
- 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 standard for patients waiting less than 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.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe good because:

- 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 electronic system 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.
- Staffing levels and skill mix were planned to ensure the delivery of outpatient, diagnostic and imaging services at all times.
- All medicines in outpatients 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.

We also found:

- Alcohol hand sanitising gel dispensers in the ground floor outpatients waiting area and diagnostic and imaging department entrance were empty.
- Staff in the diagnostic and imaging department did not observe best practice guidance on hand washing or using sanitising gel between patients.
- The first floor outpatients' department corridor created a risk as it would have been difficult to move wheelchairs or a bed in the corridor.

Outpatients and diagnostic imaging

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.
- 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).
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that 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 was a culture of reporting incidents promptly within both the outpatients and diagnostic imaging departments. Incidents were audited on the trust's electronic reporting system by the trust's governance and safety team.
- There were 14 open incidents on the day of the inspection in diagnostics and 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. We saw evidence of emails to lead staff members outlining their responsibilities to investigate the incident and giving timescales for a response.
- 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 on recording and reporting incidents.
- Staff told us that feedback and learning from incident investigations was shared during monthly staff meetings. They also told us that any changes to practice implemented following an incident were communicated to staff by email in addition to being discussed at staff meetings. For example, there was a change in the recording the time and date scans on referral forms to avoid the risk of double scanning a patient.
- Diagnostic and imaging services had procedures to report incidents to the correct organisations, including CQC. At the time of the inspection, there were two open cases with the CQC which were also classified as SI's. We saw evidence that these were being dealt with appropriately with review meetings, action plans and wider learning.
- 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. Staff said they were honest with patients if clinics were running late and offered patients' opportunities to re-book appointments, and that patients were sent copies of their final report and invited to attend any relevant meetings.
- The service lead received safety alerts and was responsible for taking action to respond to relevant alerts. This included discussion of alerts at huddle meetings. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS).

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 in the outpatients department with clear signage asking staff and patients to gel their hands prior to entering. However, we noted that alcohol gel dispensers in the ground floor outpatients waiting area and diagnostic and imaging department entrance were empty. This meant the public did not have the opportunity to use hand gels to minimise the risk of germs on their hands whilst in the waiting areas.
- We did not see any staff in the diagnostic and imaging department washing their hands or using sanitising gel between patients.

Outpatients and diagnostic imaging

- 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.
- OPD had a link nurse for infection prevention and control (IPC) in the outpatients department. The departmental link nurse liaised with the trust's IPC specialist nurse.
- The outpatients department had introduced a decontamination room in the previous 12 months. Staff told us they had been advised by the hospital's decontamination consultant in developing the room. Clean equipment in the room was covered with green liners 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.
- Staff told us that some previous issues with the private cleaning contract were now being resolved. 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.

Environment and equipment

- We saw six patients waiting in the first floor outpatients' department corridor. This created a risk as it would have been difficult to move wheelchairs or a bed in the corridor. Staff told us the corridor was being used as a designated waiting area due to the waiting room having been converted into a children's waiting area. However, the first floor eye clinic had a private waiting room which had three patients waiting for eye clinic appointments and ample chairs for more patients.
- The outpatients department kept up to date medical device inventories.
- 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 department and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- X-ray equipment had regular servicing carried out by the manufacturers engineers. We saw evidence of manufacturers completed service reports. We also saw evidence of routine surveys of all X-ray equipment.
- We found the resuscitation trolleys located throughout the different OPD 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. Oxygen cylinders we looked at were all in date.
- Portable oxygen and suction equipment was available in the outpatients department. We found the equipment was checked daily.
- Staff told us that new equipment was in place across the diagnostics and imaging department. We observed the physics testing of a new piece of equipment to ensure it was safe to use. However, radiographers did not perform additional quality assurance (QA) on a regular basis. The trust radiation protection advisor confirmed work was in progress to improve compliance.
- Diagnostic and imaging staff used specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff also used personal radiation dose monitors which were monitored in accordance with the relevant legislation.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the department.
- 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.
- The contrast and bottles tests used in the diagnostic and imaging department to ensure best imaging were found to be in date.

Records

- The trust had changed their electronic records 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. However, 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. Staff we spoke with confirmed records management had improved and there was decreased use of temporary records.
- Paper based notes were kept in locked keypad trolleys. The outpatients department had introduced a key pad protected notes room 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.
- We viewed four 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.
- The diagnostic and imaging department used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients' radiological images and records were stored securely. The RIS and PACS systems interfaced with one another and there was rapid access to stored data. There was a dedicated team available to support the systems.
- In MRI and CT we looked at five patient safety checklists, all of which had been accurately completed. We reviewed three patient records on RIS and saw that the radiographers had completed them accurately, including the documentation of who checked patient identification and the recording of patient dose information. We also saw evidence that the radiographers had checked and documented patients' pregnancy status in accordance with the department's protocol.

Safeguarding

- We viewed the mandatory training spreadsheet for September 2016. This recorded that 94% of staff had up to date level 2 safeguarding training. This was better than the hospital's target of 90%.
- 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 adult's 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.

Outpatients and diagnostic imaging

- The staff we spoke with were 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.
- We saw evidence that diagnostics and imaging staff were 100% compliant with level 1 training and 92.8% for level 2 adult safeguarding training and 91.5% compliant for level 2 children's safeguarding training. We did not see evidence of level 3 safeguarding training for clinical staff working with children, young people and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- One of the radiologists had recently attended a paediatric study day which helped staff to understand the legislative framework for children's services as well as signs of abuse.
- Bank staff received the same safeguarding training as permanent staff and ad hoc training was also provided by the safeguarding team as and when required.

Mandatory training

- 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.
- Training for staff in basic life support was mandatory in the outpatients department. This included staff working on the departments' reception desk.
- Radiology managers told us that all radiographers were up to date with mandatory training. Staff we spoke with confirmed this.
- Figures for diagnostic and imaging showed compliance of 91.3% for mandatory training as a whole against a trust target of 90%.
- Staff in ultrasound told us the completion of mandatory training was more difficult in ultrasound due to staffing issues.

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.
- Training for staff in basic life support was mandatory in the outpatients department.
- Referrals were immediately logged onto the EPR, which identified patients who were at risk of deteriorating.
- The hospital had an 'in-house' radiation protection service which provided the radiation protection advisor (RPA), radiation waste advisor (RWA), and medical physics expert (MPE), with support for lasers and magnet use.
- There were radiation protection supervisors (RPS) for each controlled radiation area. Their role met the Ionising Radiation Regulations 1999. The RPA told us they had attended a three day course; but we did not speak to any of the RPS to be able to confirm the date of their last training session. Information provided by the trust following inspection showed that staff had attended RPS training.
- Dose reference levels were evident for X-ray rooms. Automatic exposure factors were used in all X-ray rooms viewed. All doses were recorded on the PACS system and dose reports could be extracted from the system and analysed if required.
- An adapted version of the World Health Organisation (WHO) checklist was used for all interventional procedures. There was 100% compliance with the previous three WHO audits in July and August 2016.
- There was a protocol for the management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste. However, there were no local rules visible on the mobile imaging equipment.
- Phlebotomy checked patients' records to ensure patients had the correct forms. Staff told us sometimes patients picked up the incorrect form for a relative or had been issued the wrong form at the referring GP surgery.

Outpatients and diagnostic imaging

- Staff told us the mislabelling of samples was a risk in the phlebotomy clinic due to multiple tests being performed. Staff also identified a risk of a tests not being done or insufficient blood being drawn. However, staff said these were rare occurrences.
- 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 managers 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.
- We observed several patients unattended in the inpatient waiting area and not situated near a call bell if they required assistance. The area was not clearly visible to other staff. This meant patients could become unwell and might not be supervised or receive assistance in a timely manner.
- 100% of qualified staff on the outpatients department had received mandatory Sepsis, blood poisoning training and this was up to date.

Nursing 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.
- We asked the hospital for the establishment and actual numbers for staff on duty. However, the hospital informed they were unable to provide the information, "due to a high variance of requirement in both OPD and diagnostics from week to week, taking account of clinic changes."

Medical staffing

- Most medical led clinics had a sufficient number of medical staff to support outpatients clinics. 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.
- Within the radiology and diagnostic centre we found a sufficient number of staff on duty to meet the daily demand of diagnostic services. However, the radiology department had 96% vacancies. These were being appropriately advertised by the hospital. Staff told us there were national shortages of specialist radiologists and ultrasonographers. Locum and agency staff were in place to cover the vacancies.

Major incident awareness and training

- Staff 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.
- There was a major incident procedure for imaging, which was part of the hospital's major incident policy.
- Diagnostics and imaging had a rolling programme of emergency planning training. This included staff being trained in the use of chemical protective suits, decontamination, and recognising chemical and biological indicators in contaminated casualties.
- 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, and updating staff at the call centre of clinics affected by strike action. Reception staff would be provided with a list of patients affected by strike action as well as patients attending clinics.

Outpatients and diagnostic imaging

- The service manager told us the hospital followed up every junior doctors' strike with a lessons learned session in the team meeting as part of the hospital's contingency planning.

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.
- 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 2012.
- 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 ongoing 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 they were complying with best practice 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.
- 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) regulations.
- However, documents for diagnostic imaging relating to the IR(ME)R and IRR99 regulations were held on the hospital's shared drive. The local rules for the hospital had not been updated since 2012. The procedures that all employers are required to have in place when using ionising radiation had also not been updated since 2012.
- The trust had established a combination of local and national diagnostic reference levels (DRLs) within radiology.
- Work was in progress for imaging to gain accreditation with the Imaging Services Accreditation Scheme (ISAS).
- Imaging protocols for radiology were regularly reviewed. For example, a new MRI Liver protocol was now in place to improve efficiency and meet best practice.
- 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.

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.

Patient outcomes

- The trust had introduced a performance pack as a result of a 'deep dive' service review. 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 was 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.
- An IRMER audit was last completed in 2014. An action plan had been put in place and actions implemented.
- The ISAS scheme provided a framework for diagnostic and imaging services to measure and ensure practice was patient-focused. The scheme involved an assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently received high quality services, delivered by competent staff working in safe environments.

Competent staff

- Staff received regular supervision and team meetings.
- 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 induction processes were in place for new outpatients' staff. All new staff completed a corporate and local induction. Induction checklist were recorded on staff electronic training records.
- There was a comprehensive induction and training programme for new radiographers which involved rotating around the radiography areas until signed off as competent. This took on average four to six months.
- There was a record of IR(ME)R training for non-medical referrers but no record of any recent update training with some of the referrers having been initially trained over three years ago. Although it is not a legal requirement, it is good practice to keep up to date with the regulations.
- Staff told us completion of mandatory training was more difficult in ultrasound due to staffing issues.
- Role development for radiographers included film reporting in plain film, breast and chest X-rays. Some radiography staff were trained in cannulation.
- Diagnostic and imaging support staff were trained in in-house competences and were able to access external courses as required.
- Staff told us that access to continual professional development (CPD) opportunities within imaging was difficult due to the previous high vacancy rate within the department but they hoped this would now improve.
- Staff 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 were plenty of development opportunities, and staff were encouraged to broaden their skills base. There were 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 outpatients department had a range of link nurses

Multidisciplinary working

- There were regular multidisciplinary team (MDT) meetings in the outpatients department.
- The outpatients department matron managed both the outpatients department at Queens Hospital and King George's Hospital.
- Staff in the outpatients department told us there was increased cross site working with King George's Hospital. However, there were no scheduled coordination meetings between diagnostics administration staff at Queens Hospital and King George's Hospital. Managers would resolve any issues by contacting their King George's Hospital counterpart.
- 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.
- The outpatients department had link nurses for safeguarding, learning disability, wound management and palliative care.
- There appeared to be no effective representation of diagnostics on bed management meetings. One diagnostic administration staff member told us they did attend the meetings but didn't understand the purpose of the meetings or their effectiveness. Staff told us interventional patients needing an overnight bed had no active representation on bed management meetings, and sometimes a bed was not available even when two weeks' notice had been given.
- Therapists including OT and physiotherapists were part of the outpatients department MDT.
- There was always at least one radiologist based in the radiology department. This ensured that radiographers could discuss queries relating to patient scans, and seek advice from radiologists.
- Staff from the bone densitometry team attended the falls MDT meeting.
- Patient information was shared with GP's following hospital attendance to ensure continuity of care.
- The service manager attended the cancer programme board on a weekly basis with senior managers from the hospital's cancer services division.

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.
- The radiology service provided emergency cover 24 hours a day, seven days a week across CT, ultrasound, interventional radiology, and plain film imaging.
- Both CT and MRI ran extended days 8.00am to 8.00pm Monday to Sunday. MRI also offered additional sessions from 8.00 pm to 12.00 midnight.

Access to information

- Staff across all the departments we visited demonstrated how they could access all 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.
- Staff at the anticoagulant and deep vein thrombosis (DVT) clinic told us the paper referral system did not give staff sufficient information and that referral information often needed to be "chased." We viewed the referral documentation and saw that it clearly documented that all sections of the form needed to be completed. Staff at

the rheumatology clinic also said there were issues with paper referrals. For example, staff were spending time tracking outcomes of blood tests and X-rays or whether the requests had been completed.

- The radiology department used a nationally recognised system to report and store patient images. The imaging department's picture archiving and communication system (PACS) allowed access to all imaging from anywhere within the trust.
- 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 an outpatients department co-ordinator who took all calls and messages to the service and disseminated information to staff. Staff said the introduction of a co-ordinator had improved communication in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the outpatients department worked on the principle of implied consent.
- If written consent was required for more complex procedures this was obtained in outpatients' clinic by medical staff.
- Clinical nurse specialists were able to describe the process of assessing capacity when obtaining consent. We also observed staff gaining verbal consent in the X-ray room.
- 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.

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.

However, we also found:

- Privacy curtains not being drawn in the main diagnostic and imaging department and the emergency room in ophthalmology had bays that did not promote patients privacy and dignity.

Compassionate care

- 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.
- We saw the matron providing a child with a drink of water from the water dispenser in the outpatient departments' waiting room.
- Overall patients' privacy and dignity was respected. However, there was a separate waiting area for inpatients in the main diagnostic and imaging department. We saw on several occasions patients in the area without curtains drawn.
- The emergency room in ophthalmology did not promote patients privacy or dignity. The room had three bays separated by room dividers and curtains. The front area of the room was used as a patient triage area and there was also a screen in the area for conducting eye

testing. Staff we spoke with acknowledged that the lay out of the room could compromise patients privacy and dignity, but said space was an issue in the ophthalmology clinic.

- Radiographic staff we observed were professional, compassionate and caring at all times. We saw radiographers in CT scanner use a window blind in the scan room to maintain a patient's privacy and dignity when preparing a patient for a scan. However, one member of staff told us the blind was not always used.
- We saw patients being greeted in the diagnostics and imaging main reception, and staff escorting them to the correct waiting area for their procedure.
- There were separate changing cubicles for male and female patients outside the general rooms and in the ultrasound department. CT patients changed within the room. However, staff told the privacy blind was not always used. We observed it being pulled down once, but the patient was already in the room at the time and had started to undress. This did not promote patients privacy and dignity.
- We saw good patient interactions in the phlebotomy clinic. Staff members took time to patiently explain and reassure patients.

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. A patient told us, "They explain things to you and ask if you are OK with it."
- We saw nursing staff seeking consent before carrying out tasks. We also saw the matron provide directions to a patient in a corridor who was looking for a clinic.
- The matron told us the hospital planned to introduce televisions with subtitles and visual display screens to update patients on the current waiting times in the department.
- Patients told us they received instructions with their appointment letters and were given written information as required.
- 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 remind them of appointments.
- We saw reception staff in diagnostics and imaging being friendly and informative when implementing a new six point patient identification procedure that had been recently introduced.
- 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. For example, patient information sheets on robot assisted training for the upper limb after stroke' were available in the outpatients waiting area, as well as leaflets on how patients could contact the hospital's learning disability liaison nurse team.
- The outpatients department took part in the 'iWantGreatCare' patient experience survey. Departments we visited had boxes where patients could leave comments or suggestions.

Emotional support

- Staff told us Queens Hospital multi-faith chaplaincy that could provide listening and emotional support if requested to all patients.
- 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.
- The hospitals psychological service provided psychological and psychiatric consultation, assessment and therapeutic intervention to patients and their families and carers where required.
- Most patients in diagnostics and imaging we spoke with told us they were informed about their care including any investigations. One patient showed us an information leaflet the hospital had provided about attending for a CT scan and said they found the leaflet helpful.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive requires improvement because:

- The percentage of patients who did not attend (DNA) their appointment was above the England average.
- The trust's performance for the 62 day national cancer waiting time was consistently below the 85% England average from 1 March 2015 to 31 May 2016.

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 services.
- Extra imaging sessions were being provided in the evenings and weekends to meet demand.
- 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.

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 waiting 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.
- 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.
- Radiology had extended working hours, to include weekends for some examinations to meet the demand for imaging services.
- 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 with regard to redirected appointments. At the week ending 28 August 2016 the trust had redirected 6,747 patients via planned schemes with external providers.
- The phlebotomy treatment area was quite compact and slightly overcrowded. We saw the phlebotomy waiting area when it was almost completely full. There appeared to be limited space for the phlebotomy service footprint to expand. It had occupied the same area since inception and private finance initiatives (PFI) limitations seemed to hinder any change to expand to meet ever increasing need.

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. 27% were new referrals; this was above the England average of 24.8%. Most appointments were follow-up appointments and accounted for 40% of all the appointments provided; this was below the England average of 54.5%.

Outpatients and diagnostic imaging

- The hospital was using a range of private providers to assist in clearing the backlog of appointments. The deputy COO told us the hospital looked daily at patients referred to a private provider and tracked and monitored their care and treatment. The hospital met with providers weekly and identified where patients were on their care and treatment journey. The hospital was also monitoring patient outcomes within private care provision.
- The percentage of patients who did not attend (DNA) their appointment was 9.0%; 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.
- 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 hospital had conducted a cancer and clinical support divisional performance review in September 2016. The review highlighted that the hospital had introduced: a cancer programme board to monitor cancer care and treatment, daily tracking of cancer patients, and cancer away days for lead clinicians.
- 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 publicly 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.
- The percentage of people with an urgent cancer GP referral seen by a specialist within two weeks had fallen below the England average in the quarter, 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 medical director told us the challenge for the trust with regard to RTT was patients waiting 18 to 52 weeks. The medical director said there had been a number of discussions with the COO about 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 outpatients department appointment.
- The percentage of people with an urgent cancer GP referral seen by specialist within two weeks had also 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.
- The trust had introduced a cancer pathway nurse and cancer data manager with a remit of addressing cancer waiting times.

Outpatients and diagnostic imaging

- 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 June and August 2016.
- The overall follow up to new rate for the trust was in the lowest quartile of hospital trusts. From March 2015 to February 2016 the follow up to new rates for Queens Hospital were similar to the England average.
- GPs 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.
- If clinic appointments in outpatients were delayed staff told us they would inform patients verbally of waiting times. There were also notices informing patients of waiting times for clinics.
- Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge.
- 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.
- Waiting times for diagnostic imaging appointments were regularly monitored. In June 2016, 94% of patients were seen within thirty minutes of their appointment time. This was against a trust internal target of 95%.
- All radiology reports were done in-house, since June 2016 radiology reporting times were monitored on a department dashboard.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients seen within six weeks was 99.99% in June 2016.
- Patient waiting times, once they had arrived in the diagnostic and imaging department, varied but most patients we spoke to were seen within ten minutes.
- The outpatients department had introduced a pager system. This allowed patients to leave the outpatients area and visit the coffee shop or take a walk whilst waiting to be called into clinic.

- Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge.

Meeting people's individual needs

- The outpatients department had access to a range of support to meet their individual needs including: physiotherapy, a specialist speech and language therapist for voice, ear nose and throat (ENT) and respiratory disorders.
- 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.
- Staff at the outpatients department 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 outpatient departments 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.
- The phlebotomy clinic fast tracked patients with complex needs if these were known to the service, for example sickle cell, HIV, or pregnant women, although there was no flagging system. Staff said they were reliant on patients informing them of any individual needs.
- There was provision for bariatric patients in the form of a bariatric treatment table in the treatment room.
- Staff told us the trust's accessible communications team could provide printed information in a range of languages upon request.
- Interpreters offering both face to face and telephone interpreting could be pre-booked for patients that didn't speak English. Staff told us some members of staff also spoke other languages and could be approached to act as an interpreter. Staff we spoke with were aware that there was a list of staff members who were able to offer translation services for patients.
- Two general X-ray rooms had been enhanced to provide a more child friendly environment.
- Staff told us they would use a quiet room for general X-ray if a patient had an identified need. Staff would be made aware that more time was needed to undertake the examination and would not interrupt.
- The chief operating officer (COO) had conducted a performance review in June 2016. One of the outcomes of the review was the introduction of filtered water dispensers in waiting areas to give patients and visitors access to drinks.
- The outpatients department had recently opened a children's waiting room. This had child friendly décor and a small range of children's toys and books. We saw the matron inviting a parent to use the children's waiting room. The parent told us, "It's a good idea; it keeps the kids occupied while we are waiting. It's better than the main waiting room for them."
- 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.

Learning from complaints and concerns

- We reviewed the June 2016 outpatients department performance review report. This indicated that 85% of complaints were dealt with within 25 days and in accordance with the complaints policy. The main causes of complaints were waiting times for outpatient appointments and incorrect letters being sent to patients.
- 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.
- There were regular emails to service leads from the quality lead that included information about complaints on the regular emails to service leads looking at issues that had been raised by patients.

Outpatients and diagnostic imaging

- On the outpatients department the general information board displayed the complaints procedure.
- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the departments we visited.
- Staff had access to an easy read complaints policy for people who required information in this format.
- Staff in both the outpatients department told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If it could not be resolved by the team, staff told us people would be given the contact details of the patient advice and liaison service (PALS).
- Radiology managers told us complaints were included on the radiology business meeting agenda and on the monthly scorecard.
- 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.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led 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:

- There were a number of new senior managers that had introduced new quality assurance and risk measurement systems. However, these were not fully embedded.
- There was a lack of clarity for some of the diagnostics and imaging administration team around their roles and responsibilities.
- Some staff did not feel they had been engagedwith the services performance reviews.

Leadership of service

- We viewed the outpatients management structure flow chart. This clearly detailed the lines of accountability from the chief operating officer and head of nursing to the outpatient matron and outpatient service manager.
- Senior managers 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 variable. Senior managers told us, "overall managers and staff have embraced changed; most staff have come on board."
- Monthly outpatients' team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept

informed of developments within the trust. Most staff we spoke with felt supported and valued in their role. However, some staff said they did not feel they had been engaged in service or performance reviews.

- Staff at the pain clinic told us they were "delighted" with the support provided by the clinic manager. However, staff in the urology clinic told us there had been "no continuity with managers" and "nothing happens despite repeated discussion on service improvement." Urology staff gave us the example of the EPR system not being available in satellite clinics at Loxford and Harold Wood and this not having been resolved.
- Monthly team meetings took place to ensure staff received information and feedback regarding incidents and complaints.

Vision and strategy for this service

- Managers told us the outpatients and diagnostic imaging services were in transition. Managers told u the strategy for these services 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. Following our inspection the trust informed us That an updated Clinical Services Strategy had been approved by the trust board in January 2017.
- 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.'

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 had introduced 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.
- The trust's medical director told us the trust had established harm panels which 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.'
- 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 their waiting list targets. The medical director added 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.
- We reviewed minutes from the radiology performance meeting on 21 September 2016. The meetings had standard agenda items including incidents, the risk register, and safety huddles. Staff could also add items to the meetings agenda. We also reviewed minutes from patient administration department meetings and saw these had reviewed updates from the access board meeting and operational management group meeting dated September 2016.

Outpatients and diagnostic imaging

- There were monthly head of division and head of service meetings. Learning from divisional and service level meetings was disseminated to team leads, which disseminated learning from divisional meetings at team meetings.
- Outpatients, diagnostics and imaging had risk registers in place which outlined risks to patients or the service being delivered. Risks on the registers had the date they had been added and were regularly reviewed. For example, the outpatients risk register dated October 2016 had two risks identified, these were "poor decontamination" and "medical notes." Action plans were in place to minimise the risks, including an infection control link worker for outpatients and the use of temporary notes for patients only being used if authorised by a clinical preparation supervisor.
- Radiology had one risk on the trust wide risk register relating to a backlog of plain film reporting, dating from 2012 to 2013. Radiology staff told us work had been completed to address the issue. This had resulted in a reduction in the backlog from 15,384 reports to six outstanding reports in April 2016.
- The outpatients department had a local risk register, clinic risk profile. The register identified three risks to patients in terms of high, medium and low risks. For example, the risk register dated 7 October 2016 had one high risk identified which involved intimate invasive procedures. An action plan was in place to minimise the risk, including the use of chaperones and adherence to hospital guidelines.
- The Radiation Protection Group produced an annual report. The most recent report, 2015, recorded the group had met three times in the previous 12 months, 1 April 2015 to 30 November 2015. The report reviewed the key risk issues to the public and staff from radiation and addressed actions to minimise the risks. For example, an external provider was commissioned to advise on a new laser policy and local rules.
- The hospital had introduced a programme of supportive measures as part of the hospital's improvement programme. Clinics in supportive measures included gastroenterology, neurology and radiology.
- Diagnostic and imaging had recently introduced a service dashboard to monitor quality and risk. This was monitored by service leads. There was a lack of regular audits although the response rate for patient satisfaction surveys had increased.
- The diagnostic imaging department had a quality certificate for the ISO accreditation service on display. However, this had expired over a year ago.

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."
- Some of the senior managers were either new in post or had been there for a short period. Improvements were evident across diagnostic and imaging. However, some staff told us more could be done to listen to their concerns about the growing demand on the service and the capacity required in dealing with this.
- 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.
- Most staff we spoke in the outpatients department reported that morale was good across outpatients. Most staff across the outpatients and diagnostic and imaging departments 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.
- Staff in the imaging department said they worked together as a team and supported one another.
- 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, the boards carried posters and information for people with learning disabilities.

- The outpatients department had introduced 'you said, we did' boards. For example, the board acknowledged that the department needed to get better at "reducing delays." The boards carried the results of the NHS friends and family test (FFT) for August 2016, this recorded that 47 people had completed the FFT and 80.9% of respondents were likely or extremely likely to recommend the service to their friends or family.
- The matron had introduced 'meet the matron' sessions. These were session where patients, families and carers could ask the matron about staff and services.
- 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.

Staff engagement

- Some of the diagnostics and imaging administration team said there was a lack of clarity around their roles and responsibilities.
- 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.
- A local manager told us, "There has been a lot of hard work from staff this year. Staff have felt overwhelmed at times."

Innovation, improvement and sustainability

- Most of the staff we spoke with reported improvements at the hospital. The medical director conceded that waiting lists were still long, but highlighted the improvements the hospital had made over the previous 12 months in reducing these.
- The hospital had introduced the 'performance pack' to 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.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which significantly improved the quality of life for families.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

Areas for improvement

Action the hospital MUST take to improve

- Take action to improve levels of resuscitation training
- Ensure there is oversight of the training done by locum doctors, particularly around advanced life support training
- Take action to improve the response to patients with suspected sepsis
- Take action to improve poor levels of hand hygiene compliance
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.
- Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment
- Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

Action the hospital SHOULD take to improve

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Increase paediatric nursing capacity
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores.
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes.
- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Continue to monitor hand hygiene across non-compliant 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.

Outstanding practice and areas for improvement

- Make patient information leaflets readily available to those whose first language is not English.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- 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 the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- 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.
- There is improved access for beds to clinical areas in diagnostic imaging.

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 15 HSCA (RA) Regulations 2014 Premises and equipment There was inadequate compliance with fire safety standards and staff did not have sufficient understanding of local fire safety procedures. Environmental safety management was inconsistent for children's services. This included unsecured areas used to store items that could be dangerous to children, including sharps bins, chlorine tablets and clinical equipment. These concerns must be addressed, including

This section is primarily information for the provider

Requirement notices

1. Ensuring fire safety is maintained by ensuring fire doors are not forced to remain open and fire safety standards are appropriately implemented.

2. Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment.

3. Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

This was a breach of Regulation 15(1)(a) and 15(1)(d)