

# Barking, Havering and Redbridge University Hospitals NHS Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Requires improvement



Are services at this trust responsive?

Inadequate



Are services at this trust well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

The trust has a total of 1,084 beds consisting of 972 general and acute, 80 maternity and 32 critical care. The trust receives around 73,00 inpatient admissions, 592,000 outpatient attendances and 245,000 emergency department attendances. All core services are provided from both sites with the exception of birthing services which are provided from the Queen's Hospital site only.

The trust covers a population of around 750,00 across three local authorities; Barking & Dagenham which has very high levels of deprivation (ranked 8th of 326 local authorities) and is also rated as worse for a higher number of public health indicators including obesity and smoking, Havering (ranked 177th) and Redbridge (ranked 116th).

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

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

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

Overall, this trust requires improvement. Both Queen's Hospital and King George Hospital are rated as requires improvement. Of the five key questions that CQC asks, we rated the trust as requires improvement for caring, safe, effective, and well-led and responsive was inadequate.

### Our key findings were as follows:

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

#### Safe

- Safety was not a sufficient priority. There was a backlog of serious incidents and the quality of investigations into serious incidents lacked detail to ensure failings were understood and lessons were learned.
- There were insufficient systems, processes and practices to keep patients safe. Lessons were not learned and improvements were not made when things went wrong.
- Recruitment had been on-going however there was not always enough medical and nursing staff to meet the needs of patients.
- The management of medicines needed improving to ensure safe administration and a reduction in medication errors.
- The majority of clinical areas were visibly clean and staff adhered to good infection control practices.
- Most staff groups achieved completing 85% of mandatory training.

#### Effective

- Patients needs were assessed and care and treatment was delivered in line with evidenced-based guidance.
- Patient outcomes were varied.
- Some staff were not competent in carrying out their roles.
- Pain relief and nutrition and hydration needs were assessed and met.
- Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were well understood by the majority of staff and part of a patient's plan of care.

#### Caring

- Some national surveys have found that staff are not always compassionate. In response, staff had focussed on involving patients, keeping them informed and treating patients with dignity and respect.

# Summary of findings

- During our inspection we saw and heard of compassionate and kind care and emotional support being provided.

## Responsive

- Urgent and emergency, children and young people and outpatients services were not responsive to meet patients needs.
- The emergency department was not meeting the national four-hour waiting time target introduced by the Department of Health.
- The hospital was persistently failing to meet the national waiting times target. Some patients were experiencing more than 18 weeks from referral to treatment time (RTT).
- The access and flow of patients throughout the hospital had improved since our last inspection. The introduction of the Elderly Receiving Unit (ERU) met patients needs.

## Well-led

- The new executive team was making improvements. The board was visible and engaging with patients and staff.
- The leadership and culture were open, transparent and focussed on improving services.
- At an executive level there was a vision and strategy in development to deliver good care and ensure sustainability. At a service level staff were less clear and many told us they were "fire-fighting".
- The governance structures did not ensure that responsibilities were clear and that quality, performance and risks were understood or managed.

We saw several areas of outstanding practice including:

- The values of the trust - passion, responsibility, innovative, drive and empowerment (PRIDE) were well known and embedded in the culture of the people working at the trust.
- The new executive team were visible and engaged.
- There was lots of involvement from the local community and voluntary organisations. The foyer had lots of people giving information for patients and visitors about services in the local area. For example dementia care, stop smoking and healthy eating.
- Radiotherapy was one of the top five units in the country.

- The genitourinary medicine (GUM) clinic had an excellent service with appropriate protocols and processes and support for patients.
- There had been a number of initiatives to provide a responsive service for general surgery patients. The surgical assessment unit provided a timely service in emergencies and the 'hot clinic' reduced delays for patients.
- The hospital was a regional centre for upper gastrointestinal conditions. Outcomes for patients receiving oesophago-gastric cancer services were good.
- There were good outcomes for stroke patients and the stroke service demonstrated good team work.
- Play specialists had developed a way to distract children awaiting MRI scans which involved joining other children and families on a 'train journey' from the outpatient's clinic down through the hospital corridors, using storytelling and positive reinforcement on the way. This had proved a good distraction for children and reduced their anxiety. We walked with one child and found them to be very engaged in the trail.
- Consultant paediatricians undertook short notice or 'HOT clinics', whereby GPs could make a consultant to consultant referral reach a joint decision on action including if needed early assessment. GP's reported positively to their commissioners on the success of this system.
- The consultant led critical care outreach team's seven day service had improved the outcome for patients through appropriate identification of deterioration and appropriate escalation.
- The critical care outreach team provided a 'critical care follow up outpatient clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their discharge.
- Neuro-intensive therapy unit encouraged diaries for patients who were staying for longer periods of time in the unit. Patient's families kept a record of daily activities such as visits, progress and treatments, items of news and the weather. A free newspaper was offered to patients in general critical care to help orientate them.
- The development of the Elder's Receiving Unit had improved frail, elderly patient care.
- A dedicated team to support patients living with dementia . Wards could book a dementia trained

# Summary of findings

health care assistant to support one or more patients in a bay on the ward. We were told this was, “A huge improvement” as they were dementia trained. Previously this role was done by a different bank nurse every day.

- The nurse led oral chemotherapy service was the first in the country.
- The hospital performed well in the National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme carried out in 2014.
- The end of life care service was patient focussed and end of life care needs was well understood by the majority of staff from all staff groups.

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

Importantly, the trust must:

- Have clear governance with integrated systems and processes to support staff to provide care and treatment safely.
- Ensure serious incidents are understood, investigated and lessons are learned promptly.
- Review systems for sharing good practice across the divisions and trust wide.
- Ensure compliance with all national guidelines and trust policies for medicines management.
- Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
- Improve the IT systems so they are up to date and the IT strategy is implemented and supports clinical staff to carry out their duties.
- Ensure all services for neonates, children and young people are responsive to their needs.
- Ensure that radiology is fit for purpose and fulfils its reporting timescales, particularly for CT scans.
- Continuously review staffing levels and act on them at all times of the day.
- Include a dietician as part of the critical care multidisciplinary team in line with the core standards for intensive care guidance.
- Comply with the Duty of Candour legislation.

- Display the numbers of staff planned and actually on duty at ward entrances in line with department of help guidelines.
- Ensure safe management and administration of medicines.
- Ensure that all incidents including patient falls are accurately reported.
- Ensure that patients who sustain a fall receive a medical review in a timely manner.
- Ensure that medical outlying patients have an identified medical team to review their care and an agreed escalation plan in place.
- Ensure that speech and language therapists are trained and competent to care for patients who have tracheostomies.
- Ensure that entries made by medical staff in patient records comply with the expected professional standards.
- Ensure that medical staff in the emergency department receive appropriate supervision.
- Ensure adequate provision of resuscitation equipment in outpatients.
- Ensure compliance with COSHH regulations
- Ensure patient records are kept securely and that patient confidentiality is maintained.
- Comply with infection control code of practice in respect of hand hygiene audits, training and monitored improvement.
- Ensure locum and agency staff are competent and implement a formal induction process for all locum and agency staff in the relevant areas they care for patients.
- Ensure processes are in place for locum and agency staff in respect of accessing and using IT systems required for their role.
- Ensure patient risk assessments are acted upon.
- Review the general medicine on-call rota to ensure it meets the needs of patients.
- Meet the Emergency Care standards in the Elder’s Receiving Unit.
- Audit and monitor the patient outcomes from the trust discharge strategies.
- Comply with the National Dementia Strategy.

In addition the trust should:

- Consider increasing the target rates for mandatory training.

# Summary of findings

- Review the effectiveness of the rota co-ordination for junior doctors
- Review the accessibility of the radiology services and consider a duty radiographer structure.
- Review the service level agreement for accessing therapies to ensure it meets patients needs promptly.
- Continue to improve patient record availability at outpatient clinics.
- Assess the culture of staff within radiology and the anti-coagulation service to ensure they feel part of the organisation.
- Review the environment in outpatients to improve the waiting and reception areas.
- Review the environment and the staffing levels of the day-care surgery unit.
- Review nurse staffing levels and skill mix on surgical wards, particularly out-of-hours.
- Review the medical staff cover for the medical wards at night at King George Hospital.
- Review the staffing levels on Ash Ward.
- Ensure that nurses understand the importance of the recommendations stated by the speech and language therapy team.
- Review it's response to major incidents including equipment, staff training and practical testing.
- Review the availability and presence of consultant obstetricians and speciality registrar level doctors so that labour ward cover is in line with local and national recommendations.
- Consider an increase in establishment in the dementia team and the pain team.
- Review the audit programme in surgery so that internal audits are completed and implemented.
- Consider ways to increase multidisciplinary team working within critical care.
- Consider ways to make the overnight accommodation for visitor to patients in general intensive care less austere.
- Consider ways to engage patients in providing feedback specifically related to critical care services.
- Continue to increase the availability of medical records.
- Monitor the impact on patients from the reduction in Coronary Care Unit beds.
- Review the processes for medicines to take away on discharge.
- Consider undertaking a needs analysis in respect of those whose first language is not English.
- Improve engagement between junior doctors and management.

Significant progress has been made over the past year by the trust for which the leadership team should be commended. In particular we observed a marked improvement in the culture within the trust. However, considerable further improvement in quality and safety of care is still required across multiple services before these can be considered 'good'. In addition further work is needed to ensure robust governance systems are in place across the trust. I am therefore recommending that the trust should remain in special measures. CQC will re-inspect key aspects of care within the next six months to make a further determination on this.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Barking, Havering and Redbridge University Hospitals NHS Trust

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

Accident and emergency (A&E) departments operate from both of these hospitals. It also provides services from the Barking Hospital but does not manage them. King George Hospital was built in 1993 and is the main hospital for Barking and Redbridge. The PFI Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for Havering, Dagenham and Brentwood. There are plans to reconfigure services between King George Hospital and Queen's Hospital.

Barking and Dagenham ranks 8th of 326 local authorities for deprivation whilst Havering and Redbridge are less deprived areas ranking 177th and 116th respectively. Barking and Dagenham is also rated as worse for a higher number of public health indicators including obesity and smoking.

Following inspection in October 2013 the trust was placed in special measures and has since had the support of the Trust Development Authority in the delivery of an extensive improvement plan.

The trust is facing significant financial challenges with a projected 2014/15 deficit in the region of £32 million.

The inspection was a comprehensive follow up inspection of a trust in special measures that was also rated as risk level 1 by CQC intelligent monitoring.

## Our inspection team

### Our inspection team was led by:

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

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

**Queen's Hospital Inspection Lead:** Hayley Marle, CQC

**King George Hospital Inspection Lead:** Damian Cooper, CQC

The team of approximately 60 included CQC inspectors, a planner, analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, anaesthetist, physician and junior doctors; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses; paramedic, an imaging specialist, outpatients manager, child and adult safeguarding leads, a student nurse; dementia care specialist and experts by experience.

## How we carried out this inspection

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

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

- Is it well-led?

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

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care

# Summary of findings

- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

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

We carried out an announced visit between 2 and 6 March and unannounced visits on Saturday 14 March 2015 and Friday 20 March 2015. We observed how people

were being cared for and talked with patients, carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, midwives, allied health professionals, and administration staff. We interviewed senior members of staff at the hospital and at the trust. Approximately 50 members of staff attended our 'drop in' sessions to talk with a member of the inspection team.

The CQC inspection model focuses on putting the service user at the heart of our work. During our inspection we had a stall in the main reception of both hospitals for a day. Approximately 50 people shared their current views and experiences of the services.

## What people who use the trust's services say

### Friends and Family Test (FFT)

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 20%, which was worse than the national average of 53%.
- The average Friends and Family score for inpatients was 73, which is the same as the national average. The response rate was 45%, which was better than the national average of 38%.
- The Friends and Family score for maternity (antenatal) in July 2014 was 70, which was better than the England average of 62. The score for maternity (birth) was 55, which was worse than the England average of 77. The average score for maternity (postnatal) was 46, which was worse than the England average of 65.

### Patient led assessment of the care environment (PLACE)

Performed worse than the England average for measures of "cleanliness", "food, privacy/ dignity/wellbeing" and facilities in 2014. Risk identified for privacy, dignity and wellbeing in intelligent monitoring indicators.

### Accident and Emergency Survey 2014.

Trust did not perform 'better than any trusts' for any of the questions in the Accident and Emergency survey 2014.

The trust performed worse than other trusts in responses to the following questions in 2014:

#### Safe

- Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?
- Q31. In your opinion, how clean was the A&E Department?

#### Caring

- Q12. Did the doctors and nurses listen to what you had to say?
- Q15. Did doctors or nurses talk to each other about you as if you weren't there?
- Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Q8. Were you told how long you would have to wait to be examined?
- Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?
- Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?
- Q22. If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you?

# Summary of findings

- Q43. Overall score.

## Responsive

- Q9. Overall, how long did your visit to the A&E Department last?
- Q18. Were you given enough privacy when being examined or treated?

## NHS Choices ratings.

Only five ratings were provided for the trust as a whole so an overall star rating is not provided, ratings for Queen's Hospital and King George Hospital are provided in the 'site level' sections below.

## Facts and data about this trust

### Barking, Havering and Redbridge NHS Trust - Facts and data about this hospital

#### Context

Number of sites and locations Two Main sites: King George Hospital and Queen's Hospital

Areas covered Barking and Dagenham, Havering and Redbridge.

Services provided Full range of general inpatient, outpatient and day-case services, as well as maternity services and a 24-hour Emergency Department and Urgent Care Centre.

Main commissioning CCG Redbridge CCG.

Population served Approximately 750,000 people.

#### Life expectancy

Barking and Dagenham Approximately 75 for men and 80 for women in the most deprived areas in the borough.

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

Redbridge Approximately 77 for men and 83 for women in the most deprived areas in the borough.

# Summary of findings

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

Barking and Dagenham 8 / 326

Redbridge 116 / 326

Havering 177 / 326

## **Number of beds 1,084 (of which)**

972 General and acute

80 Maternity

36 Critical care

# Summary of findings

## Number of staff employed 5,445 (of which)

891 Medical

1,886 Nursing

2,668 Other

Finance

Annual revenue £457.5 Million (2013/14)

Deficit £38.2 Million (2013/14)

Financial forecast for 2014/15 £29.7m deficit

## Activity

Inpatient admissions (excluding emergency admissions):  
71,972 (2013/14)

Outpatient attendances: 411,918 (2013/14)

A&E attendances (2013/14): 244,720 (of which)

200,903 Type 1

9,316 Type 2

34,501 Type 3

Births: 9,479 (2013/14)

Deaths in hospital: 2,174 (2013/14)

## Bed occupancy

Average bed occupancy: 93% (2013/14)

## Incidents

Never events (2014) 2 (One unexpected death, one misplaced NG tube)

Serious incidents (2014)

165 (Includes 33 grade 3 pressure ulcers, 29 slips/trips/falls, 17 unexpected admissions to the neonatal unit, eight unexpected deaths, seven ambulance delays and three child deaths)

## CQC Inspection History

Number of inspections 23

Most recent outcome Rated 'inadequate' - put under special measures

## Intelligent monitoring

Total risks and breakdowns 5 'Elevated Risks' and 10 'Risks' in the December 2014 Intelligent monitoring report.

Number of 'risks' and 'elevated risks' highlighted in the December 2014 Intelligent monitoring report.

**Note:** Risks are determined mainly through use of statistical tests where indicator scores are compared to an expected value (usually an average), and then flagged as a "risk" or "elevated risk" depending on the difference between the actual and expected values. Other risks are determined by a rules-based approach, for example: concerns raised by staff to CQC (and validated by CQC) are always flagged as a risk in the model, whereas repeated concerns are flagged as an 'elevated risk'.

Breakdown of 'elevated risks' from December 2014 IM report

- **Effective** - Composite of knee related PROMS indicators (risk in previous IM report)
- **Caring** - Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (Elevated risk in previous IM report)
- **Responsive** - Composite indicator: A&E waiting times more than four hours (Elevated risk in previous 3 reports).
- **Well-led** - TDA - Escalation score (Elevated risk in previous three IM reports)
- **Qualitative information** - Whistleblowing alerts (Elevated risk in previous IM report)

6.3 Breakdown of 'risks' from December 2014 IM report.

- **Effective** - Composite indicator: In-hospital mortality - Infectious diseases (Risk or elevated risk in previous three IM reports)
- **Effective** - SSNAP Domain 2: Overall team-centred rating scores for key stroke unit indicator.
- **Caring** - Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (Risk in previous IM report)
- **Caring** - Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (Risk in previous IM report)
- **Caring** - Composite of PLACE indicators

# Summary of findings

- **Caring** - A&E Survey Q19: If you needed attention, were you able to get a member of medical or nursing staff to help you?
- **Caring** - A&E Survey Q14: Did you have confidence and trust in the doctors and nurses examining and treating you?
- **Caring** - A&E Survey Q22: If you were feeling distressed while you were in the A&E Department, did a member of staff help to reassure you?
- **Responsive** - Composite indicator: Referral to treatment (Risk in previous IM report)
- **Responsive** - A&E Survey Q18: Were you given enough privacy when being examined or treated?

## Key intelligence indicators

### Safety

- Two never events in 2014 (One unexpected death, one misplaced NG tube).
- 165 serious incidents in 2014 (Including 33 grade 3 pressure ulcers, 29 slips/trips/falls,

17 unexpected admissions to neonatal unit, eight unexpected deaths, seven ambulance delays and three child deaths).

- Clostridium difficile: 42 cases for Trust as a whole between April 2013 and September 2014 (safety thermometer). Trust level target for the year is 40. A total of 26 cases were reported by the trust between April 2014 and January 2015.
- MRSA: Three cases for trust as a whole between April 2013 and September 2014 (safety thermometer). Trust level target for the year is 0. Five confirmed (and one unconfirmed) case of MRSA between April 2014 and January 2015.

### Effective

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

### Caring

- NHS Friends and Family test (July 2014) – average score for urgent and emergency care was 20%, which was worse than the national average of 53%.

- The average Friends and Family score for inpatients was 73, which is the same as the national average. The response rate was 45%, which was better than the national average of 38%.
- The Friends and Family score for maternity (antenatal) in July 2014 was 70, which was better than the England average of 62. The score for maternity (birth) was 55, which was worse than the England average of 77. The average score for maternity (postnatal) was 46, which was worse than the England average of 65.
- Cancer Patient Experience Survey (2013-14) – The trust as a whole had an 84% rating for ‘Patient’s rating of care’ as ‘excellent’/‘very good’, scoring within the lowest 20% of trusts.
- CQC Adult Inpatient Survey (01 June 2013 to 31 August 2013) – Two risks and one elevated risk was identified in the trust as a whole for the questions to the following questions. Risks: "Did you find someone on the hospital staff to talk to about your worries and fears?", "Do you feel you got enough emotional support from hospital staff during your stay?". Elevated risk: "Did you get enough help from staff to eat your meals?"

### Responsive

- A&E, four-hour target – Average of 85% of patients seen within four hours within the whole trust in 2014.
- Referral-to-treatment times – Referral to treatment rates better than both the standard and the England average up until November 2013 (after which there are no data).

### Well-led

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

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>Overall we rated the trust as requires improvement for safety. The trust has significant issues in the management of a backlog, and quality of reporting, of serious incidents. Infection control was well managed and the trust was developing it's approach to ensuring duty of candour.</p> <p>Safeguarding structures were good but suffered from the overall lack of governance resource and structure. Similar to incidents the demonstration of learning from safeguarding was not apparent.</p> <p>Recruitment of nursing is challenging with high sickness rates in some areas contributing to staffing levels below that expected for safe care. Consultant cover in some medical services fell below national guidelines.</p> <p><b>Incidents</b></p> <ul style="list-style-type: none"><li>• The trust has a significant backlog in the completion of investigations and reports into serious incidents notably in emergency care, medicine and surgery. In some cases a delay of greater than six months had occurred prior to initiation of investigation. At the time of our visit 102 serious incidents were open and 57 overdue.</li><li>• Policies for 'incident reporting including serious incidents' and 'management of investigating and learning from incidents' were not current and therefore did not reflect current national guidance.</li><li>• We reviewed investigation reports and found them to be of poor quality lacking detailed analysis and recommendations that could lead to service improvement. There was little evidence that staff involved in incidents were involved in investigations whilst some core services indicated a lack of medical involvement in investigations.</li><li>• The trust was not utilising those staff trained in investigating serious incidents by root cause analysis (RCA) and further to that were not maintaining these skills via update training.</li><li>• Staff were largely aware of incident reporting processes, however evidence of learning and subsequent service improvement could not be demonstrated in a number of core services.</li></ul>	<p><b>Requires improvement</b> </p>

# Summary of findings

## Cleanliness, infection control and equipment

- The 2013/2014 infection, prevention and control annual reported that the trust had performed well with its audit programme and had introduced and embedded various methods to prevent and control infection since the CQC inspection of October 2013.
- Across all core services we observed adherence to infection control procedures and policies with use of appropriate protective equipment. Departments were supported by a link nurse structure.
- Staff did not identify access to equipment as an issue and our observations found equipment generally maintained and clean. However, in the outpatients department at King George Hospital insufficient and unchecked resuscitation equipment was identified. Of concern was that no action had been taken to remedy this when previously identified by the trust resuscitation officer. There was also no O2 access for patients using a treadmill.
- We received a number of reports relating to irregular CT scanning service due to equipment failure.
- Staff reported IT systems across the trust as being difficult to use and access with a lack of system connectivity that inhibited good practice.

## Duty of Candour

- The trust had recently introduced staff guidance for duty of candour and made provision for inclusion in incident reporting processes.
- The trust had retrospectively looked at 91 serious incidents and contacted patients for whom duty of candour had not been discharged. However, we saw little evidence of the involvement of patients or families in investigations.
- At core service level we saw varied levels of understanding of duty of candour. This included reports of governance leads being highly knowledgeable through to clinical staff having little understanding of requirement or availability and access to training.

## Safeguarding

- The trust has an appropriate safeguarding lead in the deputy chief nurse who acts as a single point of contact between the trust and external agencies. Representation on local adult and children safeguarding boards is in place.
- The safeguarding leadership team was viewed as enthusiastic and highly committed.

# Summary of findings

- A trust wide safeguarding strategy is in place whilst development of safeguarding practice is driven by a Safeguarding Working Group.
- The safeguarding team reported good support from key executives and an annual safeguarding report is received by the trust board.
- All directorates attend the operational safeguarding groups for both adult and children to ensure dissemination of learning.
- The overall trust governance structure is not providing appropriate support to ensure disseminated learning.
- In most core services we identified awareness and compliance of practice and training. The emergency department at Queens did however have a low training compliance.

## Staffing

- Nursing staffing levels in the emergency department at Queen's Hospital were not robust with nursing rotas demonstrating the department to be fully staffed on only a few occasions. Nurses on ICU at Queens Hospital were on occasions allocated the care of more than one patient and we identified poor nursing and HCA ratios on medical wards.
- Medical staffing recruitment was actively pursued however in emergency medicine, maternity and end of life care consultant coverage was below expected levels and guidelines.

## Assessment of patient risk

- Across the trust we saw evidence of the use of early warning scores to assess patient risk. However, within the emergency department at Queen's Hospital we raised concerns relating to the rapid access to treatment (RATT) pathway. When we returned on an unannounced visit we saw that appropriate changes to the pathway had been made.
- Capacity issues at the emergency department at King George Hospital led to more than one patient being cared for per cubicle leaving patients with limited access to call bells.

## Medicines

- Clinical areas received daily weekday visits from pharmacists to perform checks and medicine reconciliation. This was supported by access to the patient's GP summary care records.
- Medicines, including controlled drugs, were stored in a safe and secure manner.
- Medication errors were recorded on the trust IT system and reviewed at the safe medicines practice group.

# Summary of findings

- During our visit we escalated directly to the executive team our observations around the prescribing of controlled drugs within the critical care unit at Queen's Hospital. Immediate and appropriate action was taken.

## Are services at this trust effective?

Overall we rated the trust as requires improvement for effectiveness. Whilst patient outcome standards were generally met we found some departments not consistently following guidelines and some audits not completing a full cycle.

Staff induction and competency was largely well managed however the practice and process in some areas gave concern.

### Evidence based care and treatment

- Most core services demonstrated the use of evidence based protocols, guidelines and policies. However, in the emergency department at Queen's Hospital such protocols were not always followed and we found out of date guidelines in medicine at King George Hospital.
- The trust has invested in an extensive programme of sepsis training, however we observed a patient being treated outside national guidance for sepsis in an emergency department setting.
- We saw evidence of audit programmes, links to national research and best practice groups in a number of areas of the trust.

### Patient outcomes

- Intelligent monitoring mortality tree analysis indicated no evidence of risk for a wide range of conditions with the exception of infectious diseases.
- We saw evidence that patient outcome data was monitored and discussed by clinical teams and quality of care audits were used extensively across the trust. The emergency department vital signs audit had not been repeated since 2014.
- The critical care outreach team had initiated a leading edge service in the shape of a consultant led service that delivered daily consultant ward rounds to those patients in non critical areas of the hospital. This had led to a reduction in cardiac arrest calls by 34%.

Requires improvement



# Summary of findings

## Competent staff

- Most core services were providing induction for new staff and agency staff. Appraisals and supervision alongside competency assessment were largely in place. However some areas notably emergency department, medicine, surgery and phlebotomy had less robust processes.

## Multidisciplinary working and seven day services

- We observed good MDT working in many areas of the trust, with an inclusive approach to all staff groups in patient care. There were some concerns expressed around links between paediatrics and surgery whilst access to paediatric physiotherapy and general speech and language therapy services was reported as limited.

## Consent, Mental Capacity Act and Deprivation of Liberty safeguards

- Processes for taking consent were appropriate and adhered to across the trust. Understanding of Mental Capacity was variable across the trust and Mental Capacity Act training was not included in mandatory training.

## Medicines

- The trust had a formulary which listed medication the pharmacy stocked with guidance on their prescribing. This was used to promote rational, cost effective prescribing and any amendments to formulary had to be approved by the drug and therapeutics committee. We saw this formulary, along with the trust antimicrobial prescribing guidelines was easily accessible to all staff via the trust intranet.
- We saw the trust had not responded to the 2010 National Patient Safety Agency (NPSA) rapid response alert 'Reducing harm from omitted and delayed doses' by doing any regular audits to check how many doses were omitted or delayed. We saw omitted doses were recorded on the trust incident reporting system but no annual audits were being completed. Staff on the wards did not know which medicines were on the critical medicines list (medicines which must be given within two hours of prescribed time).

## Are services at this trust caring?

We rated the trust as requires improvement overall for caring. Although results of the national accident and emergency survey and the cancer patient experience survey indicated a lack of consistency,

Requires improvement



# Summary of findings

we observed staff behaviour that largely supported the provision of a caring culture. However, within outpatients some of the behaviour seen prevented patients from accessing staff for advice and reassurance.

We saw examples where patients and carers were involved in patient care.

Patients, carers and staff all had access to emotional support, however some elements of the physical environment did not show due consideration to patients.

## Compassionate Care

- Although pre inspection data suggested that compassionate care had been an issue in some services, notably in the emergency department, during our inspection we saw many examples of, and a consistent approach to, the provision of compassionate care. This included the use of comfort rounds and a good awareness of cultural needs of patients and carers.
- Feedback from patients and carers during the inspection was complimentary of care and support provided to them.
- Facilities generally provided for appropriate privacy and dignity. However, the relatives room within the emergency department at King George Hospital was not considered suitable. Phlebotomy waiting areas were highly congested.

## Understanding and involvement in patients and those close to them

- Feedback from patients and carers and our observations during inspection indicated that efforts were made to ensure that communication was clear regarding treatment plans and that patients and carers were well informed. This included verbal communication and the use of leaflets and information sheets.
- The therapy support to mothers post delivery was described as empowering.

## Emotional Support

- Patients, carers and staff had access to emotional support. The chaplaincy was readily available as a route of support and we saw examples and mechanisms of support to carers following bereavement. Staff could also access support.
- Children's services were well served by psychiatric and psychological support and the use of play specialists.

# Summary of findings

## Are services at this trust responsive?

Services at this trust are rated as inadequate for being responsive. Despite considerable attention the trust has particular challenges with emergency department access targets and subsequent flow through the trust.

Arrangements in both Children and Young Persons services and Outpatients and Diagnostics are rated as inadequate. Outpatient pathways are not appropriately planned, tracked, validated or reported and Children's services do not take account of patient needs in terms of environmental design and service configuration.

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

- The service planning for children's services was not responsive to local needs. Our inspection identified issues relating to capacity for level 2 care for neonates and the inappropriate caring of high dependency patients on low dependency wards. The trust continues to work with local CCG's to address this.
- The physical environment for children's care was not always of the standard required. Subspecialty areas lacked child friendly design and arrangements for paediatric phlebotomy were inadequate and lacked any empathetic approach to children or parents visiting the services. We saw examples of children older than three years having to attend adult phlebotomy and waiting in excess of two hours to be seen incurring significant distress.
- The introduction of the Elderly Receiving Unit to support the care of complex elderly patients admitted through the emergency department has had a significant contribution to improving the pathway for this cohort of patients.
- The roles of the Frail Elderly People Advice and Liaison (FOPAL) and the Proactive Elderly Advanced Care planning (PEACE) has reduced the number of inappropriate admissions through the emergency department.
- Outpatients departments and notably phlebotomy were not designed or planned to support the demands of activity. Clinic profiling had not been completed inhibiting service design resulting in patients attending clinics when there was no expected appointment. Seating capacity left patients without access to a chair during busy periods in many clinics with phlebotomy extreme in it's congestion. Reception areas were of poor design and poor staffing levels leading to backlogs for patients.

Inadequate



# Summary of findings

- Women were offered choice by the maternity service including the midwifery led Queens Birth Centre. Access to services provided by maternity were capped in agreement with commissioners to assure safe levels of activity.

## Meeting individuals needs

- We saw evidence of a dementia strategy with a trust wide dementia team employed. This was largely supported by our observations of patient screening, staff training and patient risk identification. However dementia screening was less robust in some areas and the environment for dementia patients in medicine could be more sensitive to the needs of patients.
- Staff were aware of the needs of patients with learning difficulties and we saw the employment of patient passports.
- The Patient Advice and Liaison Service (PALS) had a visible and accessible office, with appropriate facilities to talk to people in private, and staff with communication skills in British Sign Language and some community languages. They were integrated into the work of the wards in addressing issues raised by patients at the earliest opportunity. The Improving Patient Experience Group, which included patients and members of the public, as well as PALS, the patient experience facilitators and other trust staff, was chaired by the deputy chief nurse. Support groups, such as The Brain Tumour Charity, organised stalls in the foyer of the hospital to provide information to the public.

## Access and flow

- The trust was not robustly maintaining 18 week referral to treatment times, This was exacerbated by issues relating to tracking and record validation as the result of introducing a new IT system. There was significant concern about the number of patients awaiting notification of appointment.
- The trust has more rigorously applied controls to ensure minimising hospital cancellations of outpatient appointments which peaked at 37% in September 2014. We also observed clinics overrunning as a result of overbooking.
- The emergency pathway had received significant support and attention but attainment of the four hour access target remains a significant challenge to the trust. Patients had long waits and delays in ambulance handover.
- The trust faces significant capacity pressures which it has tried to address with initiatives including the aforementioned ERU and the ward of the week (for best discharge record). A 'plus one process' had been introduced which whilst designed to facilitate flow had not proved popular with staff as it had the

# Summary of findings

potential to lead to substandard care. The capacity shortfall leads to a high number of daily medical outliers and we heard that as a result access to medical review and appropriate access to patient records had been challenging. Pathways requiring critical care beds were being disrupted by a lack of capacity.

- Arrangements for paediatric surgery lacked clarity around age thresholds for surgery. Post surgery recovery arrangements did not separate children and young people and adults. Arrangements for adolescent patients did not include provision of dedicated bays and we reported a general lack of appropriate transitional care arrangements.
- Discussions with core services suggested inconsistent access to radiology support. This included obtaining advice from consultant radiologists and service downtime due to equipment failure. There was a backlog in radiology of reporting of 37,000 chest x rays, largely generated through the emergency department. Reporting radiographers had been introduced to help address this.

## Learning from complaints and concerns

- Across all core services there was limited evidence of learning from complaints and concerns being applied to service improvement. We identified areas where complaints response was slow leading to backlogs, lack of action planning and absence of thematic analysis.

## Medicines

- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday and there were pharmacists on call out of hours. At Queen's Hospital, on weekends and bank holidays there was an extra discharge team comprising, a pharmacist and two pharmacy technicians. These were based on ERU/MRU to support discharge specifically while the main dispensary was open. Once the main dispensary closed it then provided a discharge service to the rest of the hospital with a focus on discharge prescriptions and urgent items.
- At Queens Hospital there were three pharmacy technicians who had been trained to transcribe (copy out) discharge prescriptions in preparation for checking and signing by a doctor. We were told this meant TTA medicines were ordered

# Summary of findings

more promptly and reduced the time patients had to wait their medicines before going home. There were plans to train four more pharmacy technicians to extend this service to more wards.

## Are services at this trust well-led?

The trust is rated as requires improvement for well led. The trust has considerably improved its management capability at both executive and non-executive levels and there is clear drive to deliver improvements in care and a sustainable clinical and financial strategy. Significant improvement has been identified since the last inspection.

However enhanced focus is required on clinical governance and safety structures and processes which in their current state do not provide for robust risk assessment and mitigation, incident investigation and reporting or drive a learning organisation culture.

### Vision and strategy

- Within the core services staff were largely aware of the trust values and PRIDE initiative.
- The need for clear clinical strategy was acknowledged by executive and board team members. The newly appointed medical director eloquently described the process for clinical strategy development and the importance of authentic clinical involvement in its development.

### Governance, risk management and quality measurement

- Amidst many improvements within the trust since our last inspection, governance, risk management and quality measurement is an area of significant concern as little improvement has been made. Despite the commissioning of an external review into SI management, improvements in this area lack the pace injected into other areas of the trust.
- Previous cost reduction plans had significantly reduced the infrastructure to support governance and safety. Despite recent improvements including a revised divisional structure and a developing recruitment plan for divisional governance support this structure currently remains insufficient to support the needs of a trust this size. There is a heavy reliance on individuals and the use of short term interim staff.
- The initial spike in serious incident reporting backlog in October 2014 had roots in an overreliance on key individuals and a lack of directorate performance management.

Requires improvement



# Summary of findings

- Although a demonstrable improvement in board engagement in patient safety since the arrival of the current chief executive was described by staff we heard that support for a business case to supplement the safety team had been difficult to gain both support and approval.
- The trust has recently implemented an integrated local risk management system.
- A safety improvement plan had been submitted as part of the Sign up to Safety Campaign however the document was considered by staff as rushed and late in its submission leading them to question its authenticity.
- Directorate risk registers exist but review of reports to the trust executive committee indicated that regular reassessment was not occurring with action plans remaining outstanding for thirteen red rated risks.
- Resource to support safety systems was limited with an over reliance on key individuals. The local risk management system did not link to serious incident tracking or complaints which is contrary to current guidance and common practice.
- The trust 'Guardian Service' provided a route for staff to report patient safety concerns. There was a lack of clarity as to how this good initiative linked in with the trust's safety governance to drive change or how feedback was provided.

## Leadership of the trust

- The chief executive had been in post since April 2014 and had recently recruited to a number of executive posts bringing strength and experience to the team.
- The chair had been in post since February 2014 and had recently overseen the appointment of a number of highly experienced non executive directors and had clear sight of strategy and board development needs.
- Our contacts with staff throughout the inspection highlighted the visibility and accessibility of the chief executive with staff being highly complimentary of the chief executive's impact on the organisation.
- All executive and non executive directors interviewed had a clear understanding of their unitary and corporate responsibilities for patient safety.
- Patient safety walkabouts by members of the executive team occurred but lacked planning and structure with no evidence of a feedback loop leading to improvement.
- There was no named board level champion for children and young persons services.

# Summary of findings

## Culture within the trust

- Staff at all levels of the trust generally described the culture within the trust as open and transparent with the visibility and openness of the chief executive doing much to enhance this.
- Staff largely felt supported and encouraged, however teams at King George Hospital and some administrative teams described a feeling of being unsupported.
- Across all grades of staff there was a sense of determination to improve the trust.
- A sense of community pervaded the trust.

## Fit and proper persons

- An appropriate recruitment process was in place to ensure board members met fit and proper persons regulation.

## Public and staff engagement

- We met with staff side representatives who were positive about the new executive team. However, they had recently been in a period of dispute subsequent to the trust not adhering to a newly agreed management of change policy. Staff side described planned fortnightly meetings with executive representatives as erratic and considered the equality and diversity agenda to be underdeveloped.
- We met several members of the trust volunteer workforce who were highly committed to both supporting the trust and patient experience. They contributed effectively to an impressive approach to front of house management.
- Consultants attending focus groups were very positive about working at the trust whilst also describing concerns around trust capacity and finding time to develop clinical leadership. As a body they welcome engagement in the development of clinical strategy.

## Innovation, improvement and sustainability

- The trust had an improvement plan 'unlocking our potential' that encompassed work streams focusing on workforce, care and governance, patient flow, leadership and outpatients. Progress was reported to the board and supported by a TDA Improvement Director.
- The December progress report rated progress against actions as green for leadership, amber for outpatients, care and governance and patient flow whilst workforce was rated red. In terms of impact of completed actions leadership was rated amber with all other work streams rated as red.
- The trust has developed a 'buddy' system with another trust to enhance opportunities for improvement.

# Summary of findings

- Staff feedback indicated concern regarding the sustainability of 'running hot' to address performance issues and also suggested that areas that are performing well are not receiving attention or development support.
- The trust had committed to a programme of public engagement that included four listening events within the last year
- The trust, and the chief executive in particular, made good use of social media as a means of engaging with staff and public.

# Overview of ratings

## Our ratings for Queen's Hospital

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

## Our ratings for King George Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement					
Minor injuries unit						
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

# Overview of ratings

Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology						
Neonatal services						
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	Not rated	Requires improvement	Inadequate	Requires improvement	Inadequate
Overall	Requires improvement					

## Our ratings for Barking, Havering and Redbridge University Hospitals NHS Trust

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

### Notes

# Outstanding practice and areas for improvement

## Outstanding practice

- The values of the trust - passion, responsibility, innovative, drive and empowerment (PRIDE) were well known and embedded in the culture of the people working at the trust.
- The new executive team were visible and engaged.
- There was lots of involvement from the local community and voluntary organisations. The foyer had lots of people giving information for patients and visitors about services in the local area. For example dementia care, stop smoking and healthy eating.
- Radiotherapy was one of the top five units in the country.
- The genitourinary medicine (GUM) clinic had an excellent service with appropriate protocols and processes and support for patients.
- There had been a number of initiatives to provide a responsive service for general surgery patients. The surgical assessment unit provided a timely service in emergencies and the 'hot clinic' reduced delays for patients.
- The hospital was a regional centre for upper gastro-intestinal conditions. Outcomes for patients receiving oesophago-gastric cancer services were good.
- There were good outcomes for stroke patients and the stroke service demonstrated good team work.
- Play specialists had developed a way to distract children awaiting MRI scans which involved joining other children and families on a 'train journey' from the outpatient's clinic down through the hospital corridors, using storytelling and positive reinforcement on the way. This had proved a good distraction for children and reduced their anxiety. We walked with one child and found them to be very engaged in the trail.
- Consultant paediatricians undertook short notice or 'HOT clinics', whereby GPs could make a consultant to consultant referral reach a joint decision on action including if needed early assessment. GP's reported positively to their commissioners on the success of this system.
- The consultant led critical care outreach team's seven day service had improved the outcome for patients through appropriate identification of deterioration and appropriate escalation.
- The critical care outreach team provided a 'critical care follow up outpatient clinic' for patients who required support after leaving hospital. This ensured patients were making progress in the months following their discharge.
- Neuro-intensive therapy unit encouraged diaries for patients who were staying for longer periods of time in the unit. Patient's families kept a record of daily activities such as visits, progress and treatments, items of news and the weather. A free newspaper was offered to patients in general critical care to help orientate them.
- The development of the Elder's Receiving Unit had improved frail, elderly patient care.
- A dedicated team to support patients living with dementia . Wards could book a dementia trained health care assistant to support one or more patients in a bay on the ward. We were told this was, "A huge improvement" as they were dementia trained. Previously this role was done by a different bank nurse every day.
- The nurse led oral chemotherapy service was the first in the country.
- The hospital performed well in the National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme carried out in 2014.
- The end of life care service was patient focussed and end of life care needs was well understood by the majority of staff from all staff groups.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the trust MUST take to improve

- Ensure clear governance with integrated systems and processes to support staff to provide care and treatment safely.
- Serious incidents must be understood, investigated and lessons are learned promptly.
- Review systems for sharing good practice across the divisions and trust wide.
- Ensure compliance with all national guidelines and trust policies for medicines management.
- Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
- Ensure the IT systems are up to date and the IT strategy is implemented and supports clinical staff to carry out their duties.
- Ensure all services for neonates, children and young people are responsive to their needs.
- Ensure the radiology is fit for purpose and fulfils its reporting timescales, particularly for CT scans.
- Ensure staffing levels are continued to be reviewed and acted on at all times of the day.
- Include a dietician as part of the critical care multidisciplinary team in line with the core standards for intensive care guidance.
- Comply with the Duty of Candour legislation.
- Display the numbers of staff planned and actually on duty at ward entrances in line with department of help guidelines.
- Ensure safe management and administration of medicines.
- Ensure that all incidents including patient falls are accurately reported.
- Ensure that patients who sustain a fall receive a medical review in a timely manner.
- Ensure that medical outlying patients have an identified medical team to review their care and an agreed escalation plan in place.
- Ensure that speech and language therapists are trained and competent to care for patients who have tracheostomies.
- Ensure that entries made by medical staff in patient records comply with the expected professional standards.
- Ensure that medical staff in the emergency department receive appropriate supervision.
- Ensure adequate provision of resuscitation equipment in outpatients.
- Ensure compliance with COSHH regulations
- Ensure patient records are kept securely and that patient confidentiality is maintained.
- Comply with infection control code of practice in respect of hand hygiene audits, training and monitored improvement.
- Ensure locum and agency staff are competent and implement a formal induction process for all locum and agency staff in the relevant areas they care for patients.
- Ensure processes are in place for locum and agency staff in respect of accessing and using IT systems required for their role.
- Ensure patient risk assessments are acted upon.
- Review the general medicine on-call rota to ensure it meets the needs of patients.
- Meet the Emergency Care standards in the Elder's Receiving Unit.
- Audit and monitor the patient outcomes from the trust discharge strategies.
- Comply with the National Dementia Strategy.

The trust should also consider:

- Consider increasing the target rates for mandatory training.
- The effectiveness of the rota co-ordination for junior doctors
- Review the accessibility of the radiology services and consider a duty radiographer structure.
- Review the service level agreement for accessing therapies to ensure it meets patients needs promptly.
- Continue to improve patient record availability at outpatient clinics.

# Outstanding practice and areas for improvement

- Assess the culture of staff within radiology and the anti-coagulation service to ensure they feel part of the organisation.
- Review the environment in outpatients to improve the waiting and reception areas.
- Review the environment and the staffing levels of the day-care surgery unit.
- Review nurse staffing levels and skill mix on surgical wards, particularly out-of-hours.
- Review the medical staff cover for the medical wards at night at King George Hospital.
- Review the staffing levels on Ash Ward.
- Ensure that nurses understand the importance of the recommendations stated by the speech and language therapy team.
- Review its response to major incidents including equipment, staff training and practical testing.
- Review the availability and presence of consultant obstetricians and speciality registrar level doctors so that labour ward cover is in line with local and national recommendations.
- Consider an increase in establishment in the dementia team and the pain team.
- Review the audit programme in surgery so that internal audits are completed and implemented.
- Consider ways to increase multidisciplinary team working within critical care.
- Consider ways to make the overnight accommodation for visitors to patients in general intensive care less austere.
- Consider ways to engage patients in providing feedback specifically related to critical care services.
- Continue to increase the availability of medical records.
- Monitor the impact on patients from the reduction in Coronary Care Unit beds.
- Review the processes for medicines to take away on discharge.
- Consider undertaking a needs analysis in respect of those whose first language is not English.
- Improve engagement between junior doctors and management.