

Barking, Havering and Redbridge University
Hospitals NHS Trust

King George Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT or the 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 Victoria Centre and Barking Hospital but does not manage them. King George Hospital was built in 1993 and is the main hospital for Barking and Redbridge. 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 from King George Hospital to Queen's Hospital.

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

This report relates to King George Hospital and there is a separate report for the overall Trust.

The findings of the inspection team identified the following areas for improvement:

The Accident and Emergency Department does not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors, and an over-reliance on locum doctors. Medical staff from other specialities are not reviewing patients within the agreed timescales and are not doing enough to relieve the burden on A&E staff. Patient flow through the Trust is poor from when they attend A&E through the Acute Medical Unit and medical wards requires improvement.

We could not be assured that patients always received safe and effective care on surgical wards, and medical wards. The completion of nursing documentation was inconsistent and if patients were transferred to King George Hospital there were no documented handovers. Delayed discharges and high occupancy rates meant that the service could not be as responsive as required and this put unnecessary pressure on departments and increased the risk of poor outcomes for patients.

Some aspects of End of Life care also need to be improved.

Administration in the outpatients department is very poor which impacts adversely on patient care.

The maternity and children's care services were good, with no significant areas requiring improvement.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

The A&E department is at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with on some occasions long waiting times for patients.

Are services effective?

The hospital had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in some of the services we visited. Effective care in the A&E department is hampered by long waiting times for patients to be seen by a specialist.

Are services caring?

National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Many patients and relatives were complimentary about the care they received and the way staff spoke with them. However, some aspects of the care provided by the End of Life need to be improved.

More work is required to ensure that improvements in care provided by all services is reflected in future national inpatients surveys.

Are services responsive to people's needs?

Overall the hospital needs to improve its responsiveness to patients' needs. Although there are some external factors which affect the movement of patients, more work needs to be done to improve discharge planning.

Are services well-led?

We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. Leadership at a more senior level was good, but some aspects need to be strengthened.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department did not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors at nights and weekends.

Overall we found staff to be caring and people were positive about their experience. The department was responsive and patients were treated appropriately to their needs although some specialities took too long to attend A&E to see patients.

There was good clinical leadership within A&E and staff felt supported by the senior doctors and nurses. However, staff did not have confidence in the Trust leadership to make the necessary improvements in A&E.

Medical care (including older people's care)

We found that the service was caring with appropriate staffing levels and skill mix. Most patients told us they felt that staff had been very supportive. However, information about patients' care and treatment was inconsistently recorded. When we looked at patient records we found examples where discharge summaries had not been completed.

Some members of staff were unaware of how to recognise and respond to a patient who had sepsis (blood poisoning). All of the wards we visited were clean and well maintained. We found that staff had access to all the equipment that they required.

Surgery

The Inspection Team could not be assured that patients always received safe care. Nursing documentation was inconsistent and people were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff. Where patients had been transferred from Queen's Hospital, there was no documented handover and staff were not always aware of a patient's medical history.

Delayed discharges and high bed occupancy rates meant that the service could not be as responsive as required. Staff opinion varied on whether the service was well-led. Regular meetings took place to monitor aspects of the service, but, due to the discrepancies we found, we could not be assured that all auditing activity was effective.

Patients told us staff were caring and they felt their needs had been met.

Intensive/critical care

The patients we spoke to in intensive care, and their relatives, felt that they had been well cared for and involved in making decisions about their treatment.

Summary of findings

The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy. This affected the service's ability to provide responsive and effective care to all patients requiring intensive care. Once admitted to the intensive care unit patients received safe and effective care from caring, qualified staff.

Maternity and family planning

Maternity and family planning services were safe and effective. Patients reported that midwives were caring and responsive and staff were positive about the service they provided.

Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Midwives used comments and complaints to improve women's experiences of care and had responded proactively to these.

Services for children & young people

Children's care services were safe and caring and patients and parents reported that staff were responsive to their needs. Parents said nurses were very caring and kind, and responded well to their children's needs. They considered that children had received safe and effective treatment and said staff were knowledgeable and helpful. Staff engaged positively with children of different ages and involved them in their care. The facilities for children were good and there was a well-equipped children's play area.

Performance information, and comments and complaints were used to improve the service.

End of life care

Patients received safe and effective End of Life care. They had support to make decisions and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patient records for end of life care were completed in a timely fashion. However, patients and families had negative views about some aspects of the EOL care service. Also discharges were not as fast as required due to the length of time taken to complete the referral form.

Outpatients

The outpatient service did not always provide safe and appropriate care. There were instances where patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Most patients found the staff caring, but care was not always responsive. Patients received treatment and follow-up appointments. Some clinics were very busy and patients had to wait, but staff were caring and waiting times

Summary of findings

were displayed although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. The service had a high number of patients who did not attend their appointment and there were a high number of cancelled and delayed clinics.

Summary of findings

What people who use the trust's services say

The Trust scored low overall on the Friends and Family Test, especially in Accident & Emergency.

The Trust scored 19 in the July A&E Friends and Family Test with a response rate of 10.2%. Scores over the last four months have ranged from 12 in April and 21 in June,

results which place Barking, Havering & Redbridge in the bottom ten trusts nationally for this component of the test. However, these results should be treated with caution due to the low response rate for the A&E section of the test.

Areas for improvement

Action the trust **MUST** take to improve

- Waiting times in the A&E department must be reduced
- Increased number of permanent senior medical staff in the A&E department
- The care provided in the medical, surgical care services and end of life service
- The management of sepsis
- Discharge planning and movement of patients through the hospital to ensure patients are cared for on the appropriate wards and clinical areas and discharged when they are well enough.
- Management of the appointment times in some of the outpatient clinics
- Documentation relating to patient care.
- Sharing information to monitor performance and quality of care
- Cleanliness and infection control in operating theatres
- Job planning for consultants to enable them time to travel between the two hospitals and attend ward rounds and outpatient clinics

Good practice

Our inspection team highlighted the following areas of good practice:

- The e-handover system in the medical services which allows doctors to manage their workload more effectively.
- Patients were positive about the care they received from staff, many of whom were positive about working for the Trust.
- The virtual ward which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- The inspection team was impressed with the care provided to patients who have had a stroke, with the Trust performing well against a number of data indicators and was in the first (highest) quartile of all units.

King George Hospital

Detailed findings

Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Our inspection team was chaired by the Chief Inspector of Hospitals and included a range of specialists: consultant surgeon, consultant haematologist/medical director, junior doctor, senior nurses and a student nurse, midwives, a hospital manager, patients and members of the public.

Why we carried out this inspection

We inspected this Trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are introducing our new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care according to our new surveillance model. This looks at a wide range of data, including patient and staff surveys, hospital

performance information and the views of the public and local partner organisations. Using this model, Barking, Havering and Redbridge University Hospitals NHS Trust was considered to be a high-risk service.

How we carried out this inspection

Prior to the visit we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew about the Trust. We carried out an announced visit from 14–17 October 2013. During the visit we held focus groups with a range of staff in the hospital, nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the Trust.

Are services safe?

Summary of findings

The majority of the services we visited were safe but improvements are needed to maintain safety. Insufficient numbers of full-time, permanent medical staff King George Hospitals means that, on occasion, the A&E service is unsafe. The hospital has tried to mitigate some of the risk by employing locum and agency staff but, at times, locums who are new to the Trust may be the most senior doctor in the department. This places significant pressure on them and other staff and increases the risk of patients receiving suboptimal care.

There were vacancies in most departments and many wards relied on bank nurses (staff who work in the Trust as overtime), agency nurses and locum medical staff who, on occasions, were unavailable.

The hospital is finding it difficult to recruit staff due to national shortages in some specialties and its reputation acquired through negative media reporting of past CQC inspection findings.

Arrangements to minimise risks to patients are in place, including incident reporting, infection prevention and control, child protection and safeguarding vulnerable adults, but some areas, such as the environment and nursing documentation, need to be improved.

The provider is not meeting all the standards. Improvements were needed.

Department of Health NHS Staff Survey, only 52% of staff who responded said that hand-washing materials were always available, which was worse than expected. The Trust responded to this by installing hand-washing facilities at the entrance to clinical areas. During our inspection we observed staff washing their hands and that gloves and aprons were available although at times were not used by all staff, by most staff.

The Trust has set its own targets of zero cases of meticillin-resistant staphylococcus aureus (MRSA) and 40 for Clostridium difficile (C. difficile). Between July 2012 and June 2013 the number of reported patients with C. difficile was 56, significantly lower than the expected number of cases taking into account the size of the Trust and the number of cases reported nationally. Similarly, the number of patients with MRSA reported during the same period (9) is within an acceptable range.

All the wards we visited were clean but in the theatres we observed some poor practice related to staff not washing their hands as required and not using stickers to show when equipment had been cleaned as per Trust policy. Some equipment was quite dusty.

Staffing

The Trust is aware that staffing is an area for improvement. There are vacancies across many staff groups and recruitment is underway. In the meantime bank and agency staff are used to fill vacancies on shifts, although there were times when they were unavailable.

The Trust faces significant difficulties in recruiting medical staff for A&E, and has done since 2011. The Trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen's and King George Hospitals. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

Induction for locum and agency staff is variable and sometimes consisted of being shown around the ward.

Some staff told us there were adequate staff to meet patients' need while others felt staffing levels were at a minimum and unplanned absences were difficult to manage. We did not see any examples of patients not having their needs met through lack of staff. Although staff

Our findings

Incident reporting/Never Events

An electronic incident reporting system is in place and incidents are monitored and investigated by ward managers or matrons. Learning was shared through a range of mechanisms: intranet, email and weekly ward/unit meetings, although we were told these did not always take place.

To minimise the occurrence of Never Events, the hospital is using the World Health Organization (WHO) safety checklist in theatres, which is regularly audited.

Cleanliness and infection prevention and control

The Trust has improved its arrangements for the prevention and management of infection control. In the 2012

Are services safe?

were able to meet patients' needs, they did not have sufficient time to complete patient records of care. This was a common issue across both medical and surgical wards and both hospitals.

Patients attending the outpatient clinics did not always see their named doctor due to clinics being cancelled when the consultant did not arrive due to other planned activities or leave was required at short notice.

Documentation

Nursing staff on both medical and surgical wards were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen's and King George Hospitals with transfer checklists not always completed which meant staff may not be aware

of a patient's needs – as in the case of one patient who had diabetes which was not recorded. Staff told us they did not have time to always complete the “paperwork” but knew their patients and the care they required.

Environment

We found problems with the environment in the theatres: the corridors were cluttered with trolleys and equipment due to a lack of available storage space.

Safeguarding vulnerable adults and protecting children

Staff had received training on safeguarding vulnerable adults and child protection. They understood the policies and processes and knew what action to take if they needed to raise an alert. The Trust had a safeguarding team if staff needed support.

Are services effective?

(for example, treatment is effective)

Summary of findings

Many services provided effective care, but some services had better information gathering and monitoring systems in place. Services such as the intensive care units (ITUs) were able to demonstrate they are providing effective care. For other areas it was less clear and some were only just implementing systems to capture information to assess their effectiveness.

Improvements are needed

Our findings

Mortality rates

They hospital clinical staff can access mortality rate information. Each clinical department has access to a specific data review system which provides an early warning of outlier status. The information is included in the department's 'dashboards' (performance reporting and tracking system) and is reported to the Quality and Safety Committee.

The Trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were admitted over the weekend were at a higher risk than those admitted during the week. Actions to improve this include implementation of seven-day working for senior clinical staff, including the critical care outreach service, and better availability of specialist consultant support.

Past CQC inspections noted the Trust has received two mortality alerts from the Care Quality Commission (CQC) for Septicaemia Shunting for hydrocephalus procedures and Septicaemia (except in labour). The Trust carried out a case note review for the first alert and found "no obvious deficits of clinical or operative quality" and the case has been closed. The second case is currently being reviewed.

National guidelines

Implementation and monitoring of national guidelines varied. We found a number of services were using national guidelines. The ITUs were providing care in line with national guidelines and submitting data to the Intensive Care National Audit & Research Centre (ICNARC) on outcomes for people using critical care services to monitor its performance compared to others nationally. The data showed that the number of deaths for critical care services at King George Hospital was lower than expected. In maternity services, women received care according to best practice clinical guidelines.

Prior to the visit we reviewed the medical services log recording the Trust's implementation of National Institute for Health and Care Excellence (NICE) guidelines. A number were recorded as "partial compliance" or "awaiting response". The Trust's process for ensuring that NICE guidelines were implemented was unclear. The cardiology ward had a range of protocols and guidelines for the admission and management of cardiology patients.

Clinical audits

The hospital participated in some local and national audits and demonstrated changes as a result, such as recruiting additional bowel cancer specialist nurses.

Are services caring?

Summary of findings

Previous national surveys indicated that patients were unhappy with many aspects of their care. Many patients and relatives we spoke with were positive about the care they received. They said the nurses were “kind” and provided them with support when they needed it. People felt they had been given information when they needed it and most had been involved in discussions about their care. Staff spoke to patients in a caring way and protected their privacy and dignity.

However, some aspects of the care provided by the End of Life team need to be improved and work needs to continue to ensure improvements in the care patients receive is reflected in national surveys.

Staff were happy working at the Trust and felt things were improving.

Improvements are needed.

Our findings

The Trust has performed poorly in a range of surveys about people’s experience of inpatient care, cancer care and care in the A&E department. Although results improved since 2011, in the CQC’s 2012 Adult Inpatient Survey, the Trust scored ‘worse than other trusts’ in six of the 10 areas of questioning, and ‘within the expected range’ for the remaining four.

The Trust also performed badly in the 2012/2013 Cancer Patient Experience Survey and was rated as being in the worst 20% of all trusts nationally for two-thirds of the questions (42 out of 63).

Staff attitude

We saw many examples of staff delivering care in a kind, compassionate manner and most patients felt they were listened to and involved in discussions about their care. We saw that when patients called for support staff responded promptly. Patients described the staff as “wonderful” and said they could not have received better care. Women in the maternity and children’s services spoke highly of the staff in all areas and said staff made them feel welcome and they felt cared for.

Involving patients in their care

Many patients said they felt they had been involved in decisions about their care, and staff allowed them time to ask questions. They were satisfied with the level of information they had been given and the next stages of their treatment had been explained to them. In maternity services, women felt involved in developing their birth plans, their partners were made to feel welcome, and they had sufficient information to enable them to make choices about their care and treatment during labour.

Privacy and dignity

Staff maintained people’s privacy and dignity by drawing curtains when they were providing personal care. Wards were divided into single-sex bays with bathroom facilities. In the ITU there was enough space between each bed to allow some degree of privacy. The palliative care team tried to ensure that all patients on the End of Life care pathways were cared for in side rooms.

Nutrition

The hospital had a protected meal times policy and patients who needed assistance received their food on a red tray to ensure staff were aware. We observed staff providing support to patients with their meals as needed and monitoring their fluid intake. Following feedback from patients, the hospital had reintroduced hot meals in the evening.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The hospital has some arrangements in place to respond to patients' needs – such as the Critical Care Outreach Team. It also responds to patient feedback through the complaints process and the Friends and Family test. (The NHS Friends and Family test introduced in April 2013 allows patients to give feedback on the quality of care.) However, it has a very high bed occupancy compared to the national average, along with longer hospital stays than necessary and delayed discharges.

The hospital is not always meeting the national four hour quality indicator for waiting times in the A&E department.

While some of these issues require the involvement of partner organisations to resolve, there is much the Trust can do to improve the flow of patients which would enhance their response to patients' needs and reduce the risk of patients receiving poor care.

The provider is not meeting all the standards.

Our findings

The Trust's bed occupancy exceeds the national average and at times is at a level that is detrimental to patient care. Between April and June 2013 it was 97% while the national average is 86.5%. Once bed occupancy rates rise above 85%, quality of patient care can be affected.

Waiting times

Data shows that on some occasions patients waited more than four hours in the A&E department to be admitted to the hospital and too long to see a specialist doctor. These delays increase the risk of patients having a poor outcome. We also found delays in discharging patients from the ITU due to a lack of available beds on the wards.

Discharge

On medical wards we found that discharge plans had not always been completed and on one day of the inspection four patients were ready to be discharged but were still on the ward. The reasons for the delay had not been recorded.

Outpatient appointments

Sufficient time was allocated for consultations in the outpatient clinic but this was sometimes reduced due to clinics being delayed or over booked. Appointments were delayed between 50 and 90 minutes. Some of the delays were due to consultants carrying out scheduled ward rounds or other duties at the same time. Other issues included cancelled appointments, missing notes and patients either not receiving or having multiple appointment letters. Complaints about the appointments process and missed appointments were discussed at the Trust Board in July 2013 when it was noted that some people only had three-days' notice that their appointment had been cancelled. The Trust is aware of the problems and has started to take action, but progress is slow.

Seven-day working

The Trust is in the process of introducing seven-day working to improve patient outcomes by allowing for senior medical review and discharge of patients seven days per week. Diabetes and endocrinology services have been centralised at King George Hospital. The aim of this is to ensure senior medical staff are on site every day and improve outcomes and discharge planning.

Complaints/Patient feedback

The Trust uses the Friends and Family survey to gather feedback on patients' experience and this is discussed at ward meetings.

Work is being undertaken to improve the quality and timeliness of responses to complaints. The surgical services were aware this was an area that needed improvement.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Overall, staff were positive about their immediate clinical managers but had mixed views about more senior staff and the visibility of the executive team.

Arrangements were in place to monitor the quality and performance of services but these are being reviewed and staff acknowledged that data could be used more effectively.

The provider is not meeting all the standards.

Our findings

Leadership

The latest NHS staff survey shows encouraging improvement in a number of key findings, including the number of staff feeling able to contribute towards improvements, levels of staff motivation and the number of staff willing to recommend the Trust as a place to work or receive treatment. We found that much of this was reflected during our visit.

The 2012 General Medical Council's National Training Survey found the Trust performed below the expected range in six areas and better than expected in one area: Emergency Medicine. Junior doctors we met with during the inspection felt that consultant cover and support, along with training, was good but identified staffing levels and the general busyness of the Trust as an issue. The number of locums they worked with had an impact on the continuity of care.

Staff told us that engagement of clinical staff was good, but still in the early stages. Senior nursing and medical staff cover services across both Queen's and King George Hospitals and visit them during the week. A few staff had mixed views about how much attention King George Hospital received with some feeling there was more focus on Queen's Hospital. There was also concern about the future reconfiguration of services to Queen's Hospital.

Many staff felt they were supported by their line manager and they were part of a team. They had team meetings and felt there was good communication between different groups of staff. One member of staff said "It's a smaller hospital so things are easier to manage .." Visits to wards by non-executive directors is currently being implemented by the Trust.

Capacity

Although there were problems managing capacity and delayed discharges, they were not as severe as at Queen's Hospital. The same senior clinical staff cover both hospitals and in order for improvements to happen they need to improve their decision making and engage in making the necessary improvements.

Monitoring quality

We found many areas had team meetings where they discussed comments, complaints surveys and incidents. However monitoring actions implemented to ensure that changes take place need to be more robust. Many services have, or are in the process of developing, a dashboard (performance reporting and tracking system using a number of quality and safety indicators) to identify and monitor potential risks to patients.

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The emergency department A&E consists of a separate children's care, resuscitation, observation, major injuries ('Majors') and minor injuries area. Ambulance patients who are unwell and may need admission are assessed and directed through to the 'Majors' area, consisting of 15 bays. Once the hospital has made a decision to admit a patient they should be moved as soon as possible from the A&E to the main hospital wards or to the medical assessment unit (MAU). In the financial year 2012/13 approximately 70,000 patients attended the A&E.

We talked to six patients, three relatives and seven staff, including nurses, doctors, consultants, managers, and paramedics. We observed care and treatment and looked at care records. We received comments at our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the Trust.

Summary of findings

The A&E department did not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors at nights and weekends.

Overall we found staff to be caring and people were positive about their experience. The department was responsive and patients were treated appropriately to their needs although some specialities took too long to attend A&E to see patients.

There was good clinical leadership within A&E and staff felt supported by the senior doctors and nurses. However, staff did not have confidence in the Trust leadership to make the necessary improvements in A&E.

Accident and emergency

Are accident and emergency services safe?

Most of the senior medical staff we spoke to told us they did not think A&E was safe all of the time. One consultant told us, "We work with locums to ensure we have enough staff but they do not always know our policies and procedures. We try to stick with the same people. The locums are of various quality which gives me concerns."

Nights and weekends

Patients could potentially be placed at risk of receiving unsafe medical care by the lack of senior medical staff available at nights and weekends. The medical cover is provided by middle-grade and junior doctors with an on-call consultant covering both Queen's and King George Hospital. The Clinical Director, all of the consultants we spoke to and nursing staff expressed their concerns about this. There was a consultant on duty from Monday to Friday between 8am and 10pm. At weekends there are six hours of consultant cover on each day. During our inspection we found a patient who had been admitted after 10pm the previous night and did not appear to have received optimal care from the A&E and specialist doctors.

During one visit to the A&E we observed a patient in the resuscitation area who had possibly had suboptimal management overnight and was subsequently admitted directly to ITU approximately 12 hours after arriving in the A&E.

Staffing levels

The A&E at King George has an establishment of 76 nurses of which 66 posts are filled. Staff told us they are able to ensure there is sufficient nursing cover by using agency and in-house bank staff (who work overtime in the hospital). We examined the nursing rotas and observed the actual number of nurses on duty. We found that there were always three nurses on duty in the 'Majors' area which, for the number of patients, meant their ratio ranged from one registered nurse to four patients to one registered nurse for six patients. Staff told us they were able to provide good patient care most of the time. A senior nurse told us, "I think we could do with one more nurse on each shift, we only have one nurse for the observation area covering six patients but I would prefer two." In addition the A&E employs two accident department assistants (ADAs) who provide cover during the day. Their primary role is to record

patient indicators such as blood pressure and also take blood samples. However, when they are not undertaking these tasks, they are expected to ensure patients are supported with nutritional and personal care needs. This means that the nurses are able to focus on providing specific nursing care to patients. The A&E at King George is under-resourced for consultants. The College of Emergency Medicine recommends that the A&E at King George Hospital should provide consultant cover 16 hours a day, seven days a week. The Trust has eight consultants in post out of an establishment of 21 to cover both the A&Es at Queen's and King George Hospitals. The A&E makes up for the shortage of full-time consultants by employing locums and has a consultant working between 8am and 10pm. Staff told us that consultants do not finish their shift at 10pm unless they are happy it is "safe" to do so. After 10pm there is a consultant available on call for both hospital sites. The number of consultants in post has been decreasing over the last few years, and when we last inspected in May 2013 there were 10 consultants in post. Consultants need to be supported by middle- and junior-grade doctors. The A&E at King George is under resourced for middle grade doctors. Of the 28 posts for middle-grade doctors, 10 are filled by permanent staff, and the Trust relies on locums to make up the additional numbers. We examined the rotas for medical staff and found that, on some occasions, the most senior doctor on duty at King George was a locum. When we last inspected in May 2013 there were 13 middle-grade doctors in post.

Selection and supervision of locum doctors

Because of the low number of permanent staff, many of the doctors in A&E are locums supplied by agencies. We examined the staff rotas and found that, on many occasions, about half of the middle-grade and junior doctors at any given time were locums. Staff told us they would usually be able to employ locum staff they had previously worked with and who they trusted to deliver good and safe care. However, they said that occasionally other locums would turn up for shifts and they felt this created a risk to patients.

Accident and emergency

Are accident and emergency services effective? (for example, treatment is effective)

Patient flow

We found that there is usually good patient movement between A&E and the rest of the hospital and patients can get to wards suitable for their conditions.

On some occasions, we found that patients are waiting too long to see a specialist doctor when they have been referred by an A&E doctor. Although, one patient said, “I haven’t waited that long at all, they seem very good.” There is generally good patient movement from the A&E into the rest of the hospital.

Managing patient care

On the day of our inspection at 11.14am there were 17 patients in the whole A&E, nine of whom were in the ‘Majors’ area. For only one person, a decision to admit had been made and they were waiting for an intensive care bed to become available. The nurse in charge advised us that the MAU had spare beds if patients needed to be transferred. Two of the patients had been in the A&E for more than four hours. The Trust’s policy is that all patients should be seen by a specialist doctor within 30 minutes of referral by an A&E clinician. We examined the medical notes of the three patients who had been referred to a specialist and found that the waiting time to see a specialist doctor had been just under four hours, one-and-a-half hours, and 10 minutes respectively. Staff told us it is much more difficult to get a referral at night. This means that specialist diagnosis and treatment are delayed, putting patients at risk. One consultant told us, “Children’s care are good at responding when we call them, medicine and urology are much slower”.

Patient movement to other parts of the hospital

Staff told us that patient movement gets much worse in the winter as the number of attendances increases. One member of staff told us, “The trouble is when it gets very busy they put too much pressure on wards to discharge people, who end up coming back into the emergency department anyway.” A senior nurse told us, “We are usually fine until we get more than 50 patients in the emergency department; from this point things start to grind to a halt.” We examined the Trust’s performance for unplanned readmissions where it has set a target of no

more than 4.9%, and found that it performed significantly worse than this with 8.7%. Staff told us that the decision making between the high dependency unit, intensive care unit and the A&E was not always clear. We were told that, on a number of occasions, patients would be accepted by these or other specialties but would remain in A&E for a number of hours. This created the risk of patients being overlooked and medical reviews not being conducted, which could lead to poor outcomes for patients.

Are accident and emergency services caring?

Staff were caring and sensitive to patient’s physical and emotional needs.

The vast majority of patients we talked with were complimentary about staff in the A&E. One patient said, “I have no complaints thank you.” Another person said, “yes they have looked after me just fine, they have given me a drink and now I am waiting for them to come and take a blood sample”.

We observed that the staff treated people with respect and kindness, talking to them in a soft and responsive way. We observed that, when people called for support, a member of staff would respond efficiently.

Patients’ privacy and rights

Patients were given appropriate information and support regarding their care or treatment. Patients told us they had been involved in decisions about their care and treatment. Staff respected patients’ rights to make choices about their care. We saw staff explaining treatment options to patients to make sure they fully understood the treatment and choices available. All the people we spoke to told us that staff had kept them up to date on what was happening with their treatment

Food and drink

Patients received adequate nutrition and hydration while they were in A&E. Although the department does not have dedicated staff, we found that patients are offered food and drink. We observed that most patients had water, tea or coffee cups by their beds. The patients we spoke to said they had been offered drinks. We visited in the late morning and found that patients who had been there for a number of hours had been offered breakfast.

Accident and emergency

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

Waiting times

Nationally agreed Emergency Department quality indicators state that 95% of patients should be seen within four hours and no patient should be in the department for more than 12 hours. The Emergency Department at King Georges does not always reach this target but performs in line with most other emergency departments and better than Queen's Hospital.

Working with the ambulance service

Information provided to us by the London Ambulance Service (LAS) indicated that King George had not closed or diverted any ambulances in 2013.

The LAS also records "black breaches" (those cases where it has taken over 60 minutes from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place). Data provided by the LAS shows that throughout 2013, King George had 32 "black breaches", which compares favourably with Queen's Hospital where, for the same period, there were 222 "black breaches". However this does not reconcile with information provided by the Trust which shows that for year 2013 there has only been one breach involving four patients.

We spoke to two paramedics who told us they felt valued by the doctors and nurses in A&E. One of them told us, "They are good here; they all go quiet when we are doing a patient handover and pay attention."

Working with partners

Partners we spoke to said that the Trust was not always responsive to people's needs and that it could improve the way it works with partners. One local authority member told us, "BHRUT remains inward looking and is not yet fully engaging with local partners."

Caring for children

We found there were always trained paediatric A&E nurses on duty within the paediatric area, except at night when the area is covered by general A&E nurses. Senior staff told us that the Trust was currently recruiting additional paediatric

nurses to provide 24-hour cover. Staff had training and understood safeguarding, child protection and reporting procedures. The paediatric unit worked well with the paediatric ward, which always had a middle-grade and junior doctor allocated to the A&E paediatric area.

Are accident and emergency services well-led?

A&E clinical leadership

A&E has good clinical leadership. We spoke to the clinical director who had a good understanding of the risks and issues the department faces. We observed that consultants and senior nurses gave clear guidance and support to junior staff. Staff are motivated and there was good team working and communication between all grades of staff and they said they felt well supported by managers. One member of staff told us, "It's a smaller hospital so things are easier to manage; we have good staff and work very well as a team."

Staff had less confidence in the Trust's management to address the fundamental issues of staffing and patient flow.

Trust support for A&E

There was widespread concern from staff that the Trust has not fully supported A&E when concerns are raised. One member of staff said, "We never see any of the management over here and all the important meetings are held at Queen's." Staff also felt they were not kept up-to-date on the planned closure of the A&E at King George Hospital by senior management in the Trust. One nurse told us, "There is a lot of unrest about the closure; we feel they are doing it by the back door. It makes it more difficult to recruit and keep staff."

Managing quality and performance

The Trust has a system in place for recording and analysing clinical incidents. We examined summaries of all incidents for a three-month period prior to our inspection. We found that incidents were being properly reported but many of the records we examined were unclear about how the Trust would make future changes. We also found that a number of the incident reports indicated difficulties in getting specialist doctors to attend A&E.

Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

Information about the service

Medical services at At King George Hospital include a range of inpatient wards including an Acute Elderly Unit and two wards which provide post operative care following orthopaedic surgery and a discharge lounge.

Summary of findings

We found that the service was caring with appropriate staffing levels and skill mix. Most patients told us they felt that staff had been very supportive. However, information about patients' care and treatment was inconsistently recorded. When we looked at patient records we found examples where discharge summaries had not been completed.

Some members of staff were unaware of how to recognise and respond to a patient who had sepsis (blood poisoning). All of the wards we visited were clean and well maintained. We found that staff had access to all the equipment that they required.

Medical care (including older people's care)

Are medical care services safe?

Incident reporting

We spoke with a wide range of staff. They knew how to report a concern about care and treatment on wards and about the management of wards. We were told that, following an adverse incident, they would usually get feedback from their manager.

Staffing levels and skill mix

On all the wards we visited staff told us they felt they had sufficient staff to enable them to meet the needs of patients.

When we visited the 28-bed MAU, a unit where patients stay for up to 48 hours while a decision is taken on the best place for them to be cared in, we were told they had five trained nurses in the morning and three healthcare assistants. This had recently been increased as a result of extra funding for winter. At night there were three trained nurses on duty. Staff said they felt this was adequate to meet the needs of patients on the unit.

We visited Gardenia ward, which had 25 beds and treated cardiology patients. During the day there were five trained nurses and two healthcare assistants. At night there were three trained nurses and one healthcare assistant. The staff told us they felt this was sufficient to meet the needs of their patients.

The trust was in the process of recruiting extra consultants in the medical division to ensure that they were able to meet the needs of seven day working.

In most of the areas we visited nursing staff told us that, when they needed support from doctors, they received this promptly. Junior doctors told us that senior colleagues were usually available. However, some staff on surgical wards reported that there were sometimes delays in getting support with medical patients who were on their ward because there were no beds available.

Documentation

We looked at the documentation of care in patient notes. We noted that there were a number of gaps in the completion of nursing records and that nursing notes were not up to date. For example, discharge plans had not always been completed. Nurses told us they did not always

have time to complete the paperwork for patients, but they felt they knew their patients and were delivering good care. Senior nursing staff told us they were aware of the need to improve nursing documentation.

Environment

In general, the accommodation at King George Hospital was very good for meeting patients' needs. The wards were spacious and clutter free. Patients told us they thought it was a good environment.

We saw that single-sex accommodation was provided in all the areas we visited.

Infection control

Wards were clean and well-maintained. Hand-washing facilities and hand gels were available in most areas. We saw that personal protective equipment, including gloves and aprons, was usually available.

Staff told us they had infection control 'link' nurses on the wards. These staff linked with the Trust infection control team and provided guidance and support to ensure good practice was maintained in managing the risk of infections.

Medicines/emergency equipment

On Gardenia Ward we checked storage of medications, including controlled drugs. We found that medicines were stored appropriately and, where required, had been appropriately signed for. We saw that medicine record cards had been completed and allergies recorded where appropriate.

We checked the crash trolleys (used to transport emergency medication) in a number of wards, including on Gardenia Ward, and found they had been checked regularly by the staff. All of the medication was within expiry dates and all the appropriate equipment was arranged according to the checklist.

Patients on the wrong ward

During our inspection there were a number of patients who were 'outliers'. This means they were on wards that were not the correct specialty for their needs. We visited these patients to see how they were being managed and if they were getting the support they needed. We visited Heather Ward and looked at the care of three outlier medical patients. We saw evidence they were having their care managed appropriately by the correct medical team. When

Medical care (including older people's care)

we visited Iris Ward we were shown that patients had a named consultant whose contact details were recorded on the ward board. Nurses told us that the nursing paperwork was the same, so this made managing patients easier.

Sepsis

The Trust needs to ensure that staff are aware of how to recognise when patients may be developing sepsis (blood poisoning) and know how to respond appropriately.

When we visited we asked staff on Heather and Gardenia wards how they would recognise sepsis and how they would respond to this. None of the nurses we asked knew about guideline to use if they suspected sepsis or were able to clearly define what sepsis was. They were not aware of any specific training available on the management of sepsis. Some said that they thought a sepsis care pathway was available on the intranet but no one was able to locate it.

Are medical care services effective? (for example, treatment is effective)

Assessments

Patients' notes included initial assessments of their needs. Where required, pain scores were calculated and Braden scale scores (which identify patients at risk of pressure ulcers) had been completed appropriately. The Trust had an early warning score system to highlight when patients' health condition was deteriorating. If a patient's score increased the medical team was alerted. We saw recorded observations of this being completed.

Capacity assessments

In order to identify patients who may be confused, mini mental tests involving a number of short tasks were used to identify patients who needed extra help if suffering from confusion. The September 2013 performance report for the acute medical division records showed that 94% of patients over 75 had a test score recorded. Staff were able to describe the action they would take if a patient did not have capacity to make decisions.

Multidisciplinary working

Staff told us they felt they worked well as a multidisciplinary team and that there was good

involvement for doctors, nurses and therapists in patients' care. We saw that, when patients were identified as requiring support from specialist teams, (such as tissue viability), they received this.

Delays in discharge

On Ash Ward we looked at the records for nine patients and found that only one of them had a clear discharge plan. In four cases the discharge plan had been started and recorded that the patients were ready to be discharged home but they were still on the ward. There was no information to explain why this had not happened.

We asked staff across the Trust what happened when there was a 'black' alert (a severe lack of beds and patients waiting in A&E to be admitted). They told us they would receive an email but did not explain any action they would take to speed up patient discharge where possible.

Are medical care services caring?

Patients' view of care

Most patients were very positive about their care. Some told us they felt they were "extremely well cared for". On the MAU patients told us the nurses had been checking to see if they were comfortable.

We saw that staff treated people in a kind and caring manner. For example, when we were on Beech Ward we observed a sister taking time to engage with a patient and comfort them.

Are medical care services responsive to people's needs? (for example, to feedback?)

Seven-day consultant cover

The Trust was introducing seven-day consultant cover.

Diabetes and endocrinology services were now centralised at King George Hospital. The aim was to improve patient outcomes by ensuring senior medical staff were on site every day, and also to improve arrangements for discharge planning, to help reduce length of stays and prevent patients having to spend longer in hospital than necessary. At the time of the inspection we were told that the new arrangements had been implemented, although formal job planning had not yet taken place to enable a consultant to be on site seven days per week.

Medical care (including older people's care)

Do not attempt resuscitation recording

We saw six patient records that were marked DNA CPR ('do not attempt cardio-pulmonary resuscitation') Only two records showed that the decision had been discussed with the person or their relatives.

Support for people whose first language is not English

We asked staff how they would support someone whose first language was not English. They were able to explain how they would ask for an interpreter and told us they had never had any problems in securing one.

Virtual Ward

Since 2009, the Virtual Ward has managed patients from eight clearly defined ambulatory care pathways, allowing patients to receive care at home. Patients are identified by their consultant as medically suitable for ambulatory therapy according to strict criteria. The Virtual Ward nurses collect referral forms from MAU and arranges all tests and investigations, ensuring they happen in a timely manner. Patients can have follow-up care in the community or at the hospital. Patient satisfaction surveys for the service showed that patients valued the support and management they received. Staff told us they hoped the service could be further developed and utilised for other conditions.

Are medical care services well-led?

Staff morale

Most staff told us they felt their morale was good. On all the wards we went to, most expressed a general sense of being well supported by peers and management and that team-spirit was high.

Training

Staff they told us they felt they had good opportunities to undertake training. They told us they felt they were supported in their roles and had regular appraisals of their performance. Junior doctors told us that in general they had good support from senior doctors.

Monitoring quality

During the inspection we saw many examples of information being gathered on the performance of wards. However, this information was not currently being collated in one place to allow for the easy recognition of themes. Actions identified were not always monitored in a robust manner to ensure that changes were made. For example, there was no central log to ensure that learning actions identified from complaints had been implemented.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Surgery at Barking, Havering and Redbridge University Trust is provided across its two main sites; Queen's Hospital and King George Hospital. Queen's Hospital provides acute surgical procedures, while King George Hospital undertakes more elective procedures. Patients are also transferred from Queen's Hospital to King George Hospital for rehabilitation. Orthopaedic surgery is carried out at King George Hospital, and there are four surgical wards..

People can access the surgical services at King George Hospital via the hospital's A&E department, their GP or referral from Queen's Hospital.

We talked to patients and staff, including healthcare assistants, nurses, doctors, consultants, senior managers and therapists. We visited all four surgical wards and the operating theatres at King George Hospital. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance about the Trust.

Summary of findings

The Inspection Team could not be assured that patients always received safe care. Nursing documentation was inconsistent and people were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff. Where patients had been transferred from Queen's Hospital, there was no documented handover and staff were not always aware of a patient's medical history.

Delayed discharges and high bed occupancy rates meant that the service could not be as responsive as required. Staff opinion varied on whether the service was well-led. Regular meetings took place to monitor aspects of the service, but, due to the discrepancies we found, we could not be assured that all auditing activity was effective.

Patients told us staff were caring and they felt their needs had been met.

Surgery

Are surgery services safe?

We could not be assured that all patients received care that ensured their safety and welfare.

Documentation

When a patient was initially admitted, nursing staff completed an assessment of their needs. This included assessing the risk of the person developing pressure ulcers, having a fall, their risk of malnutrition and their mobility requirements. Where risks had been identified, there were specific 'care bundles' (additional assessment and monitoring documents) to ensure each identified risk was managed appropriately. On some wards we visited this documentation had been fully completed and was up to date. However, on other areas we found examples of where the assessment had identified risks, but the relevant care bundles had not been completed. In one patient's record, a falls assessment had been completed on 8 September 2013, but had not been updated since. The documentation stated that it should be completed weekly, or if a patient's condition changed. We also found examples of where patients were on fluid balance charts and the total inputs and outputs had not been recorded.

Patients were often transferred between Queen's Hospital and King George Hospital. For example, patients who had undergone a complex orthopaedic surgical procedure at Queen's Hospital were transferred to King George for rehabilitation. Staff told us that patient handovers were conducted over the telephone. At King George Hospital we looked at the nursing notes for patients who had recently been transferred from Queen's Hospital. There was a transfer checklist available, but these had not been completed. One nurse was not aware that a patient had diabetes..

There was a lack of documented guidance in patients' records about the care they needed in relation to their medical and psychological needs. When we asked staff how they planned a patient's care, they told us they used the "evaluation" sheets in their nursing notes. However, the notes we saw documented the care that had been provided on that shift and were task-orientated rather than including how a patient liked to be cared for or how best to support them. We were told that staff were informed of any outstanding care needs during the handover. We looked at examples of handover sheets and saw no evidence that these included how to meet patients' psychological needs.

Due to the inconsistencies in the nursing documentation and lack of recorded care planning, we could not be assured that all patients received care that ensured their safety and welfare.

Patients' medical records had evidence of multidisciplinary input from the medical team, physiotherapists, dieticians and occupational therapists, where necessary.

Managing risk

We observed a theatre team at King George Hospital. People were protected from avoidable harm through the use of "five steps to safer surgery" procedures. This included the use of the World Health Organization (WHO) safety checklist to ensure that people had consented to the procedure and that the necessary checks were completed before, during and after surgery.

There were systems in place to deal with medical emergencies. The Trust had a Critical Care Outreach Team who reviewed patients on wards whose condition may be deteriorating. Staff on the wards told us that the team were quick to respond when they required advice or assistance. All wards used the early warning score observational chart to ensure that patients who may be becoming unwell were quickly identified and their condition escalated to the outreach team or the night time on-call team. In addition, there was one resuscitation trolley available on each ward and we saw that these were checked daily by staff.

The surgical department had learned from some mistakes.

A Never Event (a serious, largely preventable patient safety incident), occurred at Queen's Hospital in 2013, where a patient had a different surgical procedure to the one they had consented to. categorised as a "wrong site surgery". To reduce the risk of this happening again, patients were not draped in surgical gowns until final checks had been completed, including checking the person's consent form.

In 2012 the Trust was a mortality outlier for septicæmia, meaning there were more deaths than expected. However, no staff we spoke with had undertaken sepsis training while working for the Trust, nor did the Trust use a best practice tool such as Sepsis Six, which is a series of life-saving interventions. In addition, we noticed that the observational charts used to respond to a patient's deteriorating condition did not prompt staff to consider sepsis.

There was an electronic incident reporting system in place. Incidents were monitored and investigated by ward

Surgery

managers and/or matrons. We were told that learning from incidents was shared with staff during weekly ward meetings and via the Trust's intranet and email messages. However, on some wards, staff told us that these meetings did not routinely take place.

Hospital infections and hygiene

The Trust infection control rates for *Clostridium difficile* (C.difficile) and methicillin-resistant staphylococcus aureus (MRSA) were within the expected ranges. There were signs and information leaflets for patients and visitors on how to prevent infections and when to avoid coming to hospital.

According to the NHS Staff Survey (2012), only 52% of staff said that hand-washing materials were available. Hand gel was available at the end of each bed and by the entrance to each ward or bay area. As a result of the staff survey, hand-washing sinks had also been placed by the entrance of each ward. The most recent Friends and Family test for some surgical wards had raised concerns about doctors not washing their hands. We were told that monthly hand hygiene audits were undertaken and staff were encouraged to challenge their colleagues. Most people had seen doctors using the hand gel to clean their hands between seeing patients.

At the time of our inspection the ward areas were clean. We observed domestic staff cleaning the wards and people told us that they had no concerns about the cleanliness of the hospital. We looked at equipment, including commodes, and saw that these were visibly clean and had a sticker applied with the date they were cleaned by staff.

However, we visited the operating theatres at the hospital and found the corridors were cluttered with trolleys and equipment due to a lack of available storage space. When we checked the trolleys and drawers, which contained theatre items, they were visibly dirty. Some equipment which would be used by theatre staff was also dusty. Staff had not used stickers (which was Trust policy) to show when equipment had been cleaned. Staff were not clear about who was responsible for ensuring the corridor was clean. We were told that infection control checklists were completed monthly or weekly if concerns were identified. We looked at these for the three months preceding our inspection and saw that the equipment and trolleys had been marked as visibly clean.

We also observed poor practice during a surgical procedure. Two members of staff answered the telephone

in theatre, but did not wash their hands afterwards. Another member of staff removed dirty swabs and instruments from a trolley inside the operating theatre and did not clean their hands before moving into a sterile area. Therefore, there was a risk of cross-contamination. Hand hygiene audits were completed weekly. While we were told that all infection control audits were sent to the Trust's infection control team, there was no evidence of any feedback when audits fell below 100%. Therefore, current audits were not effective in ensuring high standards of infection control.

Staffing

We were told that staffing levels were determined by the number of beds on the ward. Most staff said that, if there was a full complement of staff on each shift, they could manage to provide all the care patients needed. On the general surgical wards, nurses told us they usually cared for between eight and 10 patients each, but sometimes more. However, all staff said the number of staff scheduled to work each shift was the minimum required and, if there were unexpected absences, then it was challenging. Staffing levels were not adjusted to the medical conditions of people using the service. On one ward, staff told us they thought staffing levels were "unsafe" at night, particularly if they had patients who required closer observation.

The staff electronic rota system did not show where shifts had been covered by bank (in-house staff working overtime) or agency staff. We asked to see the rotas on two wards for the month preceding our inspection. On one day it showed that no nurses had been scheduled to work. We followed this up and found that bank and agency nurses had worked that day and this had been recorded in a book which was kept only on the ward. This made it difficult for senior management to monitor staffing levels and how often shifts had been short-staffed. A senior manager for the service told us there was an over-reliance on locum and agency staff.

Are surgery services effective?
(for example, treatment is effective)

Monitoring quality

The Trust used the nationally recognised Enhanced Recovery Programme for urology, colorectal and orthopaedic patients. The aim of the programme was to speed up a patient's recovery following surgery and lead to

Surgery

improved outcomes. In May 2013 the department audited 200 patients on the programme. The sample was evenly split between Queen's Hospital and King George Hospital. 80% of patients said they were involved as much as they wanted to be in their care. Pain management was better, and patients were mobilising earlier. While the length of stay for patients was higher than its target, there had been a gradual reduction between January 2013 and April 2013, some of which may be attributable to the programme.

According to the June 2013 performance dashboard, 96.7% of surgical patients were risk assessed for venous thromboembolism (VTE). This was above the target of 90%. In addition, there had been no reported grade 3 or 4 pressure ulcers. There were skin care information bundles in place for when staff identified people who may be a risk of developing pressure ulcers and input was sought from the Tissue Viability team.

Audits

The hospital participated in a variety of clinical audits. The audit for bowel cancer found that only 50% of patients were seen by a clinical nurse specialist. As a result the Trust had recruited more bowel cancer nurses so there were two nurse specialists at both hospital sites. Specialties within the department reviewed particular cases at their clinical governance meetings and participated in research.

Staff from the day case surgery team were unable to tell us how they were performing as a unit compared to others. Senior management told us that data was being collected on the performance of individual surgeons, but was not formally published by the Trust.

Are surgery services caring?

Dignity and respect

People were treated with dignity and respect. We observed staff closing curtains when providing care and talking to people about their care discreetly. Wards were divided into single-sex bays and there were designated male and female toilet facilities. Interpreter services were available if required and staff were required to attend mandatory training on caring for people with dementia. People who were confused or who had been diagnosed with dementia were discretely identified on the boards in the ward area so that staff were aware.

People were complimentary about the staff caring for them. Everyone we spoke with felt the staff were caring. People described staff as "wonderful" and "very kind". One person said that they could not have received better care.

Nutrition

When people were first admitted, their risk of malnutrition was assessed. Staff also monitored fluid intake. Staff on each ward were responsible for serving drinks and food. We observed that people had drinks within easy reach. The July 2013 Friends and Family survey had indicated that people were not satisfied with the quality of food. We were told that the Trust had reinstated hot meals in the evening time, which had been received well by patients and staff. Red trays were provided to people who needed support with eating and drinking so that staff could prioritise assisting during meal times.

On one ward at King George Hospital staff told us that nutritional drinks were not always easily accessible and that this would be raised with the dietician.

Comfort rounds were conducted on each ward to ensure that people were comfortable and not in pain. However, in some records we reviewed the comfort round charts had not been completed. There was no system in place for people who had undergone a day case procedure to receive a follow-up phone call the next day to check that they were not in pain or experiencing any adverse reactions.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Discharge planning

There was a dedicated emergency theatre list 365 days of the year, but no dedicated day case theatre list. At the time of our inspection, the day case ward at King George Hospital was being used as an over-flow area for when other surgical wards were full. People were also being nursed in the theatre recovery area and discharged home from there. Staff told us this was commonplace due to a shortage of beds elsewhere in the Trust.

We were told that people were not discharged home until they were well enough and arrangements had been made

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with other relevant services (where necessary). There was a dedicated discharge team to assist with this process, but nursing staff were able to describe the procedure should a referral need to be made to social services.

There were delays with patient discharges. Staff said this was caused by waiting for care packages to be confirmed by social services, bed shortages in the community and discharge summaries not being completed by doctors 24 hours in advance. Senior nurses told us they had attended training to enable nurse-led discharges, but this had not been implemented by the Trust. The average length of stay for surgical patients was 4.5 days, with a target of 4.45 days. This was lower than the Trust's average of 7.05 days.

Feedback from patients

According to the July 2013 Friends and Family survey, overall, the Trust performed worse than expected for how caring staff were. However, during our inspection of the surgical services, most people felt that staff were very caring.

According to the survey, people felt they had not been given enough notice when they were to be discharged or told what to expect. People at King George Hospital felt that staff had explained the process well and they knew what to expect. However, one person had been told that it was not safe for them to be discharged, but no other alternatives had been suggested, which was worrying them.

We were told that, following the results of the July 2013 Friends and Family survey, nursing staff and doctors were encouraged to spend more time with people to discuss any of their fears or concerns. People we spoke with were positive about staff communication. One person told us they understood their plan of care and felt "well-informed". Another person told us staff "provided reassurance".

The most recent Friends and Family survey results were on display in the ward areas with details of action taken.

In April 2013, only 67% of complaints from surgical patients had been responded to in line with the Trust's policy. The Clinical Director for surgery acknowledged that the complaint's procedure was poor as there was no consultant lead for it.

Are surgery services well-led?

Leadership

Staff views on whether they felt the surgical department was well-led varied between wards and staff grades at King George Hospital. All staff were proud of their job. One member of staff described it as an "excellent place to work" whereas another felt that their manager did not escalate concerns upwards. All staff were aware of the Trust's whistle-blowing policy and said they would feel comfortable using it.

Management arrangements

The matrons and medical staff worked across both sites. The matrons visited King George Hospital about once a week as the majority of surgical services were provided at Queen's Hospital. Some ward staff felt that the senior staff focused on Queen's Hospital. One person told us that King George Hospital "feels like a different Trust". Theatre teams met for an hour once a week and this time was protected. We looked at the meeting minutes and saw that clinical governance and training were discussed.

Ward managers told us they felt well supported by management and confirmed that they met weekly with their matron and colleagues. At these meetings they discussed incidents, complaints and quality of care audits. We were told that the Trust's executive team disseminated information via newsletters and emails and that staff were able to contact the Chief Executive directly. Some staff told us they did not have time to read these and relied on their ward manager to pass on key messages. Others told us these messages were sent once decisions had been made and that they did not feel involved in the changes affecting the organisation.

Monitoring quality

Clinical governance meetings took place monthly. Specialties also held their own governance meetings. We looked at the minutes for some of these and saw that they discussed deaths, patient surveys and complaints. However, a senior manager for the service told us the department needed to make better use of the data available.

A variety of audits were carried out to monitor the quality of care provided and to inform the performance dashboard. Weekly quality audits took place on each ward and involved looking at records, incidents, training and talking

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to patients. However, these audits had not identified the gaps we found in documentation. Furthermore, according to the June 2013 performance dashboard 100% of procedures had a completed WHO checklist. We were told

that, each month, the first 100 cases were audited. However, we looked at five, none of which were fully completed. Therefore, we were not assured that the provider's monitoring systems were accurate or effective.

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Barking Havering and Redbridge University Trust has a total of 40 beds in the intensive care unit (ITU). These are split across the two hospital sites of Queen's Hospital and King George Hospital. There are eight ITU beds at King George delivering care to patients, except children, with serious life-threatening illness. A Critical Care Outreach Team assists in the management of critically ill patients on wards across the Trust during the day. At night, cover is provided by the on-call team.

We visited the ITU ward at King George Hospital, observed care and treatment and looked at care records. We talked with two relatives and five staff, including nurses, doctors and consultants. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the Trust.

Summary of findings

The patients we spoke to in intensive care, and their relatives, felt that they had been well cared for and involved in making decisions about their treatment.

The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy. This affected the service's ability to provide responsive and effective care to all patients requiring intensive care. Once admitted to a critical care ward, patients received safe and effective care from caring, qualified staff.

Intensive/critical care

Are intensive/critical services safe?

Environment

At the time of our inspection, the ITU ward area and equipment were visibly clean. There were adequate hand-washing facilities with hand gel dispensers at the end of each bed and by each ward entrance. We observed staff cleaning their hands between attending to patients. The ITU was spacious and there was enough room around each bed for equipment and for staff to provide care safely. Resuscitation trollies were available on each ward and these were checked daily. Staff told us that there was enough equipment available for each bed area.

Documentation

We looked at documentation on the critical care wards and found people's needs had been assessed and that observations were recorded in a timely manner. Where people had been identified as being at risk of developing a pressure ulcer, they had been put on a skin care pathway which ensured that the condition of their skin was monitored regularly.

Staffing levels and skill mix

At the time of our inspection, all eight beds were occupied, but there was not the full, planned complement of nurses working and the ward manager had been unable to arrange for additional nurses to cover. Therefore, nurses were having to care for two level 3 patients (the most seriously ill, requiring advanced respiratory support or with multi-organ failure) each when they would usually provide one-to-one care. However, there was good medical cover as one consultant was based on each intensive care ward throughout the Trust during the day so a person's medical condition could be responded to rapidly. Comprehensive handovers took place twice daily between shifts and were attended by consultants, junior doctors and nurses to ensure that all staff were aware of the person's plan of care and treatment.

Staff working on the unit had the necessary skills and experience. All staff were trained in intensive care and had their competency checked before they worked alone. One nurse told us that they had been supernumerary for the first six weeks they worked on the unit. There was a

preceptorship programme of clinical supervision experience, mentoring and training, designed to support newly qualified nursing staff for the first six to 12 months of their roles.

Critical care outreach team

The department provided a Critical Care Outreach Team during the day, which responded to deteriorating patients elsewhere in the hospital, triggered by an alert from the early warning score observational chart used by all wards. Staff on the wards said the outreach team were usually quick to respond. We spoke to the outreach team and they told us that response times were usually 30 minutes. At night, wards were instructed to call the on-site manager who would call for medical support.

We received mixed views from staff on the response from the hospital-at-night team and the Trust was in the process of recruiting to the outreach team so that it could provide cover 24 hours a day, seven days a week.

Safeguarding

There were systems in place to protect people from the risk of abuse. Safeguarding training was mandatory for all staff. Staff were able to describe the safeguarding process and some were able to provide examples of where they had made a referral to social services. Staff also showed an awareness of the Mental Capacity Act 2005.

Are intensive/critical services effective? (for example, treatment is effective)

National guidance

People received care in line with national guidelines.

There was a set criteria for patients who should be admitted to the unit and the Critical Care Outreach Team were responsible for reviewing each patient referred to the unit to determine if it was appropriate or not.

Patient outcomes

The Trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC) on the outcomes for people using critical care services to monitor its performance compared to others nationally. We looked at the data and saw that the number of deaths for the ITU at King George was lower than expected, indicating there were good clinical outcomes for people once they were admitted to the unit.

Intensive/critical care

Transfer/discharge of patients

Transfer of patients to wards once they are well enough needs to be improved. On the day of our inspection, three people were ready to be discharged to a ward, but they were unable to be transferred due to bed shortages. This was not an effective use of the service as patients who needed to be admitted to the unit were being nursed on the wards. It also presented a potential patient safety risk should additional equipment be required.

Are intensive/critical services caring?

Dignity and respect

People were treated with dignity and respect. There was enough space between each bed to provide people and visitors to the ward with some degree of privacy.

Staff acknowledged that the ward could be noisy because of the equipment, but said that most people were understanding of this. We observed staff talking to people kindly and having a good rapport with them.

Involvement of patients in decision about their care

Patients and their relatives were involved in decisions about their care. People were positive about the staff caring for them. One person's relative described the nursing staff as "marvellous" and told us that "nothing is too much trouble for them". They told us they understood the care their relative was receiving and found staff to be supportive and approachable. One member of staff told us they felt the team as a whole "give good care".

Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Capacity

The service was not always able to meet demand due to the high level of bed occupancy on the wards and delayed discharges throughout the hospital. Bed occupancy rates in the ITU at King George were 82% between April 2012 and April 2013. In the same time period, about 50% of patients experienced a delayed discharge from the ITU and 64 people were transferred from ITU to other hospitals for

non-clinical reasons which impacted on those who needed to access the service. Medical staff described the situation as "frustrating". In order to mitigate the risks associated with transferring acutely unwell patients, a consultant would transfer the patient and provide a face-to-face handover to the receiving service. However, this was only where the patient was transferred during the day and some people were being transferred after 10pm. The fact that patients were being transferred to wards late at night when staffing levels were reduced had been identified as a risk and was on the risk register.

Feedback

People were encouraged to give feedback about their experience and we saw that the Friends and Family survey results were on display. We looked at the Trust's patient experience report which covered the period between April and June 2013. There were no reports of any concerns being raised in relation to the ITU at King George Hospital.

Are intensive/critical services well-led?

Leadership

Intensive care was a consultant-led service and staff told us they felt part of a supportive team. The senior managers and clinicians had a good understanding of the department's performance.

Monitoring quality

They had identified the risks within their service and were able to demonstrate how they were attempting to mitigate these. For example, by recruiting to increase the Critical Care Outreach Team and ensuring consultants led transfers of patients to other units during the day. Where risks had been identified, these had been placed on the risk register.

Staff told us they had regular team meetings to discuss any issues that may have arisen, such as incidents and complaints. All staff we spoke with enjoyed working on the ITU.

Senior nursing staff conducted weekly quality audits, looking at the quality of nursing documentation and feedback from people. Weekly hand hygiene audits were also undertaken.

Maternity and family planning

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The labour ward was closed at the end of March 2013 but antenatal and postnatal clinics are still provided at King George Hospital from Monday to Friday between 8.30am and 4.30pm. If a woman requires inpatient antenatal care, this is provided at Queen's Hospital. The full range of diagnostic facilities are available, along with specialist clinics for women with diabetes and mental health problems. We visited the antenatal clinic and spoke with three members of staff. We spoke to two mothers who attended clinics at the hospital.

No sexual health or family planning services are provided at King George Hospital.

Summary of findings

Maternity and family planning services were safe and effective. Patients reported that midwives were caring and responsive and staff were positive about the service they provided.

Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Midwives used comments and complaints to improve women's experiences of care and had responded proactively to these.

Maternity and family planning

Are maternity and family planning services safe?

Managing risks

Mothers were risk assessed when they first registered, and then reassessed as their pregnancy progressed. If maternal risk factors such as diabetes were identified, women were referred to specialist multidisciplinary clinics and extra care or monitoring was provided as appropriate, including screening for foetal abnormalities.

The maternity service monitored the quality and safety of care provided to women and their families. A maternity dashboard (a performance reporting and tracking system using a number of quality and safety indicators) was used to identify and monitor potential risks to patients. The dashboard was reviewed monthly and concerns were escalated. Not all staff were aware of this valuable tool.

Safety incidents were followed up, discussed widely and lessons learned disseminated to staff. An example was the recent training for all staff on using and interpreting cardiotocography (CTG) which monitors the heartbeat of the baby and the mother's contractions to identify potential foetal distress.

A named midwife carried out a regular programme of audits as well as spot checks. Audits covered topics such as care given to pre-existing diabetic women, a patient satisfaction survey for the perinatal mental health clinic, antenatal care and antenatal referrals. The findings of audits were followed up. For example, the audit for care of diabetic women revealed a need for more dietician involvement and more frequent antenatal appointments for women who were less compliant with monitoring their glucose. Findings were presented to dieticians and the Clinical Commissioning Group. Documentation has improved and more referrals were now being made to the dietician.

Safeguarding patients

We spoke to staff about safeguarding for vulnerable women. Staff were aware of safeguarding and child protection policies, and what to do if they suspected abuse. Social workers were involved and we were told that they were sometimes instrumental in encouraging women

to attend specialist antenatal clinics. Hospital staff could contact social workers from two of the three boroughs at Queen's Hospital. There was a named maternity safeguarding lead.

Staffing levels

There were sufficient numbers of staff to run the clinics and associated classes. We were told that staff turnover and sickness was low. There were both midwife and consultant-led clinics. Other specialists attended some clinics – for example, a psychiatrist attended the clinic for women with mental health problems and a diabetic specialist doctor and a dietician diabetic nurse attended clinics for people with diabetes. Child protection teams were involved in clinics for women who misused substances or alcohol.

Are maternity and family planning services effective?

(for example, treatment is effective)

Benchmarking and national guidelines

Women received care according to best practice clinical guidelines as set out by the National Institute for Health and Care Excellence (NICE). Audits were undertaken to ensure that the clinic was performing in line with similar clinics – for example, in the care of women with pre-existing diabetes, antenatal referrals to consultants and the antenatal booking process. The audit of diabetes had revealed good aspects of care in relation to being booked early by diabetes midwives, education, scans and retinal screening. It also identified a need to inform GPs of some women whose diabetes was poorly controlled. A presentation had been made to the GP forum about the results of the audit.

Supervision of midwives

Midwives had access to a supervisor of midwives for advice and support and supervision of their practice. An audit of midwives' views on supervision between November 2012 and January 2013 showed that supervision was valued by 99% of the midwives sampled and found it supportive, informative and helpful in assisting with statement writing and birth plans. Midwives told us they were supported to attend 4 days mandatory training a year and in accessing professional development opportunities.

Maternity and family planning

Are maternity and family planning services caring?

Support for women

Many women and their families spoke very highly of staff in the clinics and praised the support and reassurance they had received from staff. They were able to obtain the information they needed.

Patient involvement

Women felt involved in developing their birth plans and were given sufficient information to enable them to make choices about giving birth. The antenatal clinic offered classes in the last trimester of pregnancy which were run by midwives.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Referrals

Women said the antenatal service was responsive to their needs. They were able to refer themselves to the maternity service online. If people didn't want to have to come to a hospital, they could attend clinics at Children's Centres. Women said it was easy to change appointments and people felt they had plenty of time to ask questions. One woman who had been identified as 'high risk' and been referred to a consultant had mentioned to the midwife that that she felt she was missing out on general advice on diet and other aspects of pregnancy because she was no longer seeing a midwife. In response to this, arrangements were put in place to ensure all mothers had the chance to develop a birth plan with a midwife and attend antenatal classes.

Patients' feedback and complaints

Women's experiences of care obtained through patient surveys, complaints and comments were used to improve care. Complaints had fallen over the past year. A change in the management of staff breaks so that midwives took shorter breaks at times of high activity had improved women's experiences. Women praised staff for taking time to listen when they had concerns.

Information

Information leaflets about various topics, including tests and screening, breastfeeding and other sources of support were available in clinical areas.

Are maternity and family planning services well-led?

Leadership

The Director of Midwifery had oversight of the service. The staff thought the unit was well-led, although following the closure of the delivery unit at King George, some staff had some concerns about how long the clinics would continue to run.

Managers were based at Queen's Hospital but visit the King George site as the antenatal clinics on both sites are regarded as a single service. Staff said that communication with Queen's Hospital was good with information cascaded by email and The Link magazine which went to all staff.

Managing quality

The Trust has a Maternity Risk Management Strategy and the Director of Nursing is the named executive responsible for Maternity at the Trust Board. A number of sub-groups feed into the Maternity Quality and Safety Committee, which reports through the Women's Board to the Trust Quality and Safety Committee and to the Trust Board. Local meetings include staff at all levels, including junior and senior nursing and medical staff.

Staff monitored the quality and safety of care across the maternity service through a range of audits and spot checks. Some of these had been introduced recently and time was needed to assess their value in prompting change. We saw presentations that communicated the findings of audits as well as action plans to respond to identified concerns. Both email and face-to-face meetings were used to disseminate lessons learned and these were also incorporated in training. The unit reported performance indicators on the maternity dashboard and monitored incidents, complaints and patient feedback. A Maternity Message of the Week communicated key issues to all staff.

Staff told us they felt supported by senior managers and could escalate concerns if needed.

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

King George Hospital children's services consists of two distinct units:

The special care baby unit (SCBU) in Jasmine Ward has 12 cots and provides care for babies who require less intensive care before going home. Most babies have been transferred from the neonatal intensive care unit (NICU) at Queen's Hospital.

The children's ward in Clover Ward has its own staff (although there was a policy that newly recruited children's nurses would work on this ward as well as in the paediatric service at Queen's Hospital).

Both units are led by matrons who are based at Queen's Hospital where there are related services.

The general paediatric service has a dedicated children's outpatient clinic for urology, diabetes, respiratory and other conditions. An 18-bed ward takes inpatients as well as day patients coming into hospital for surgery or for assessment. The ward has two six-bed bays and six cubicles for patients with infectious diseases. Most children are admitted after coming to the A&E service at King George.

We talked with staff in the SCBU and two staff and parents or relatives of children in the children's ward. We observed care and treatment and looked at six care records. We also reviewed performance information about the Trust.

Summary of findings

Children's care services were safe and caring and patients and parents reported that staff were responsive to their needs. Parents said nurses were very caring and kind, and responded well to their children's needs. They considered that children had received safe and effective treatment and said staff were knowledgeable and helpful. Staff engaged positively with children of different ages and involved them in their care. The facilities for children were good and there was a well-equipped children's play area.

Performance information, and comments and complaints were used to improve the service.

Services for children & young people

Are services for children & young people safe?

Special Care Baby Unit (SCBU)

Admission criteria

The SCBU was a specialist care unit for babies who needed minimal additional support and monitoring of their breathing or heart rate, support with feeding or recovery and convalescence from other care. One mother said she was impressed with the skills and kindness of the staff and the reassurance they gave mothers.

The neonatologists were required to use clear criteria for deciding to admit a baby to or discharge a baby from the SCBU. Most babies did not stay more than a week or two in this unit. The unit was fully equipped with new-born resuscitation drugs and equipment to help babies with breathing. In the event of deterioration, a baby would be stabilised and taken back to the NICU at Queen's Hospital.

Staffing levels

The ratio of nurses to babies was generally 1:4 including a neonatal and special care nurse. As babies in the SCBU required minimal care and treatment, (mainly oversight of feeding and weight), staff thought this staffing level was sufficient. Consultants did ward rounds seven days a week.

Capacity

The cot occupancy in the SCBU was monitored daily and throughout the shift alongside the monitoring of cot occupancy in the NICU. Baby transfers between the two hospitals were co-ordinated by neonatologists and ward co-ordinators. A nurse escorted babies being transferred.

Paediatrics

Admissions

Most children who were admitted to the paediatric ward at King George had been brought to A&E by their families. Children's risks were assessed on admission and care planned accordingly. We looked at the records of six babies and children and saw that all the relevant information had been recorded.

The parents on the paediatric ward were very complimentary about the care provided by nursing staff

and were confident in the expertise of the staff. The parent of one child who had frequent admissions to the ward was unhappy that she received different advice from different doctors.

Staffing

There were sufficient numbers of nursing staff to meet the needs of children on the inpatient wards. The ratio of nurses to children was 1:5 unless a child needed one-to-one care.

The Trust had a full complement of paediatricians. Consultant paediatricians were on call at night and during the weekend. Junior doctors said consultants were accessible and supportive.

Safeguarding children

All nurses on the ward had attended mandatory safeguarding training to Level 3. There was a named nurse and consultant responsible for safeguarding of children and young adults, both based at Queen's Hospital. There were weekly multidisciplinary meetings about children of concern.

Patient safety and environment

All nurses we spoke with understood the process for reporting incidents and explained how they learned from these.

All areas in the children's unit were visibly clean. Hand hygiene gel was available and used by staff, parents and visitors on the ward.

Staff told us they had access to the equipment they needed. The environment was well maintained with toys and activities suitable for different age groups. Toys were clean and in good condition.

Resuscitation equipment and drugs for babies and children were available on the ward.

Are services for children & young people effective? (for example, treatment is effective)

Special Care Baby Unit (SCBU)

Discharge

Most babies spent only a short time on the SCBU before being able to go home. Each baby had a clear care plan and risk assessment on admission to SCBU, which often

Services for children & young people

involved gradual weaning off oxygen to prepare for discharge. There were protocols for staff responsibilities including transport arrangements for babies, sharing information and learning lessons from admissions, and these processes were audited.

Some babies who had been discharged would continue to receive support at home from the children's community service. Doctors said staff worked hard to encourage relevant parents to bring their babies back for check-ups and had improved the rate of clinic attendance.

Staffing levels and skills

In the SCBU staff were either neonatal doctors or nurses trained in neonatal nursing. There was a national shortage of such nurses and the Trust had sent some of its own staff on training to help remedy this. Agency and bank nurses (Trust nurses working overtime) were sometimes used and there were clear induction checklists for such staff. There was a mechanism for permanent staff to report unsatisfactory agency or bank staff.

Paediatrics

The parents and children we talked to in the paediatric wards said they were looked after well and said their children had prompt and effective pain relief. Parents were aware of their children's care and treatment plans and said they had been able to contribute to them. The length of stay depended on the condition of a child but the hospital's aim was always to discharge young people back home as soon as possible. Sometimes family care was supported by the children's community service.

Children were discharged with medical notes sent out to GPs or others and staff said there were rarely delays in discharging children. There was a home care team to support discharge.

Staffing levels and skills

Children on the paediatric ward were cared for by nurses trained to care for and treat children. Medical staff were also paediatricians. The Trust had its full complement of paediatric doctors. Some nurses on the ward had recently been promoted and the Trust would be reviewing the need for replacements.

The paediatric outpatient area was not busy at the time of our visit, although we were told there were 40 appointments a day. There were two consulting rooms. We were told 30% of patients did not attend for their diabetic appointments. The nurse said that the receptionist was

sometimes directed to work at Queen's Hospital and that meant they had to take on reception as well. It was not always possible to guide patients to the consulting room when this happened, and there was no way of verifying children's hand hygiene.

There was a senior house officer based at King George. Consultants and registrars rotated between children's services at King George and Queen's Hospital.

Are services for children & young people caring?

Special Care Baby Unit (SCBU)

Staff tried to minimise the time mother and baby were apart. In the SCBU mothers were often able to be more involved in the care of their baby and staff were there to support them. One mother spoke highly of the "wonderful helpfulness of staff". Parents felt that doctors communicated well with them. There was a nursery nurse who was able to give advice, guidance and support for parents on all aspects of baby care, including breastfeeding and milk feed preparation.

Paediatrics

Parents said staff cared for their children well and that their child's treatment was explained to them in a way they could understand. They felt able to raise any concerns with staff. Parents said their children received pain medication quickly when they arrived on the children's wards and they were given information about their child's medication.

Parents were able to stay with their children overnight so children felt less anxious about being in hospital. There were toys and books for children of all ages.

Are services for children & young people responsive to people's needs? (for example, to feedback?)

Paediatrics

Support for parents

Parents were pleased that beds were available for them to stay with their children on the ward. They also welcomed the availability of toys to keep children occupied during their stay.

Services for children & young people

Feedback

Staff encouraged parents to give feedback when their child was discharged and staff said they learned from feedback and used it to improve their interaction with parents and children.

Staff told us the bed base could be adjusted to cope with seasonal vacancies. More beds were likely to be needed in winter.

Staff mentioned that the ward could not easily take children with challenging behaviour because they were not staffed for this. Such children went to the Brookside child and adolescent specialist inpatient unit.

Are services for children & young people well-led?

Special care baby unit SCBU)

Management

The SCBU was closely integrated with the Neonatal intensive care unit (NICU) and doctors and nursing staff rotated between the units on the two sites. Nursing staff were managed by a newly appointed matron, who had established himself quickly in his role. Although managers were based at Queen's they also worked at King George Hospital.

Doctors and nurses said they worked as an effective team.

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators through a range of audits and monitoring risks through the risk register.

Paediatrics

Management

The matron was visible to her staff and nurses and the healthcare assistant considered they worked together as a team and with medical staff. Two staff said the ward was very well run. The matron told us that, when she first joined, there were a lot of management changes but that the structure now seemed fairly stable.

Senior managers within the paediatric service had a clear vision for developing aspects of the children's service. There were plans to rotate paediatric nurses through A&E which was intended to help liaison between that service and the ward. A meeting to discuss this was to be held shortly after our visit.

Monitoring quality

Staff told us they had regular supervision and appraisal and that there were regular training opportunities. They mentioned that management communications had improved but they sometimes felt staff at King George Hospital "got left out of the loop".

Staff said that the hospital was slow at managing poor staff performance. Quicker processes would be better for all staff because nurses who were not performing well became supernumerary.

End of life care

Safe

Effective

Caring

Responsive

Well-led

Information about the service

The palliative care team is based at Queen's Hospital. The team provides end of life (EOL) care directly to patients throughout the Trust where appropriate as well as supporting and training staff on the wards. One member of staff is based at King George Hospital Mondays and Fridays. They receive over 1,000 referrals every year. The Trust offers a bereavement service between 8am and 5pm.

We spoke with a patient, families of patients and five members of staff, including staff nurses, bereavement service officers, mortuary officers and ward sisters. We observed care and treatment and looked at two patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the Trust.

Summary of findings

Patients received safe and effective End of Life care. They had support to make decisions and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patient records for end of life care were completed in a timely fashion. However, patients and families had some negative views about the EOL care service. Also discharges were not as fast as required due to the length of time taken to complete the referral form.

End of life care

Are end of life care services safe?

Documentation

The records of two patients who had received palliative care or EOL care demonstrated that they had received appropriate care for their condition. Pain relief, nutrition and hydration were provided according to their needs. Their wishes for their end of life care were also clearly documented including if they wanted to be resuscitated. Mental capacity assessments were in place where required and patients or their next of kin signed these plans as accurate.

Staffing

The palliative care team included specialists who understood their role and were passionate about ensuring patients received good EOL care. The team was fully staffed, although they wanted further staff seconded to the service which had not been fully successful. The service had one consultant lead. The Trust had an EOL co-ordinator who trained staff on the wards in EOL care.

Are end of life care services effective? (for example, treatment is effective)

Patient's EOL care was managed effectively. Patients received effective support from a multidisciplinary palliative care team. The team, including a consultant, a lead nurse, clinical nurse specialists and a social worker, responded swiftly to referrals to ensure that patients received an effective service. An EOL care co-ordinator provided support to all patients and staff across the Trust. A chaplaincy and bereavement service was also available. Links with community services and hospices had been made to ensure families had support out of hours. All staff in the palliative team were trained to provide specialist care and expertise in palliative and EOL care.

Multidisciplinary working

Ward staff were aware of EOL pathways, although different wards told us they would request support from the palliative team for different aspects of a patient's EOL care. Some staff were reluctant to involve the palliative care team, whereas others would ask them to provide all EOL

care. All staff we spoke with felt well supported by the palliative care team, although some acknowledged that it was easier for the team to support patients at Queen's rather than King George due to being located there.

National guidelines

The EOL care team followed government guidelines. In response to the national independent review *More Care, Less Pathway: A Review of the Liverpool Care Pathway*, July 2013, the Department of Health recently asked all acute hospital Trusts to undertake an immediate clinical review of patients on EOL care pathways. The Trust had undertaken this review and had an interim policy on EOL care which replaced the Liverpool Care Pathway.

Training

The palliative care team supported ward staff to ensure continuity with EOL care when there was no direct palliative clinical support. All clinical staff had mandatory training in basic EOL every two years and more comprehensive training was also available to staff.

However, some staff felt EOL training was not flexible enough and take up of training ranged between ward areas. This meant that care could fluctuate depending on which staff looked after a patient.

Staff informed us that the Trust had introduced the Gold Standards Framework on two wards in the Trust for EOL care. The National Gold Standards Framework Centre in End of Life Care is the national training and co-ordinating centre, providing a gold standard of care for people nearing the end of their life.

Quality monitoring

Although the Trust was in the bottom 20 percent in the National Bereavement Survey in 2011 in three of six quality indicators, the Trust met their Commissioning for Quality and Innovation (CQUIN) targets for EOL in 2012/13 and were on course to meet higher standards in 2013/14. The Trust had carried out their own bereavement survey in the last year with positive results.

End of life care

Are end of life care services caring?

Patient and relatives experience

Patients and families had negative views about the EOL care service. Only some wards had relative rooms so families could have privacy. The palliative care team tried to ensure all patients on EOL pathways were in side rooms and we observed that this had been arranged.

Families of patients receiving EOL care had dedicated parking and their visiting hours were not restricted. The bereavement service had private and comfortable relative rooms. The mortuary had a viewing area that was dignified and viewing could be arranged before a post mortem was started. A multi-faith service was available for patients and their relatives.

Although they felt everything was dealt with sensitively, some patients and families felt they had not had enough input from the palliative care team and had not been fully involved in EOL arrangements. One family told us they always had to escalate their concerns to enable their relatives' needs to be addressed and had been unable to contact the palliative team directly at times. They also felt that staff treated their concerns differently as the patient was receiving EOL care; they felt staff were more concerned about making the patient comfortable rather than addressing their health needs. Another patient told us that they had been waiting to be discharged for three weeks but had not been told why there was a delay. We found that the nurse covering King George Hospital that week was on leave one of the days and the lead nurse was covering their normal palliative team duties as well as those at King George. This meant requests for patient and relatives to have face-to-face contact with a member of the palliative care team at King George was not always possible.

Information

The bereavement service had a number of leaflets to support relatives, including contacts of support organisations and networks such as counsellors as well as a step-by-step guide of what a family needs to do when a relative has died.

Are end of life care services responsive to people's needs? (for example, to feedback?)

Referrals

We saw examples of referrals to the palliative team late on Fridays and Mondays. Due to the service being Monday to Friday, this led to delays with palliative team input as no referrals could be completed over the weekend and there was a backlog of referrals on a Monday. We were told this was due to consultants not completing the necessary paperwork in a timely manner.

If the palliative team were not on site during their opening hours, a telephone advice service was available to patients, families and ward staff.

Discharge

Patients were discharged safely with the right care and support. We listened to some palliative care patient consultations with the EOL consultant, EOL nurse and ward nurses. The patient's palliative care needs were discussed in-depth, including EOL care. This included making sure support services were in place so that the patient could return home safely, psychological and religious support and a review of the patient's pain relief needs.

Although patients were fast-tracked to get immediate funding to facilitate the right home care package or nursing home depending on their wishes, this was not always done as efficiently as it could be. Staff reported that fast-track discharges were delayed due to the length of time it took to complete the referral form. This resulted in delays with arranging social care in the community due to limited providers being available through the local authorities and referrals to the palliative team being rejected for not having enough information to show that fast-track discharge was required.

Are end of life care services well-led?

Leadership

All staff were positive about their work and wanted to provide a high quality service. While many aspects of the service are good action needs to be taken to improve some aspects of the care provided to patients and outstanding issues related to referrals and fast track discharges.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Outpatient Services are located in one area at King George Hospital. The clinics run from Monday to Friday 9am to 5pm. The Trust offers outpatient appointments for all its specialties where assessment, treatment, monitoring and follow up are required. During our inspections, there were separate outpatient clinics for neurology, trauma, cardiology, chest, geriatric, pain, general medicine, epilepsy, hepatology, orthodontics, dermatology, vascular, ear, nose and throat (ENT), ophthalmology, stroke, chiropody, orthopaedic, urology, endocrinology, rheumatology, maxillofacial, anaesthetics, breast, general surgery, paediatrics, obstetrics and anti-coagulation.

During the inspection we talked with eight patients and five members of staff, including booking and clerking staff, doctors and consultants. We observed care and treatment. We received comments from our listening event, from people who contacted us to tell us about their experiences, and we reviewed performance information about the Trust.

Summary of findings

The outpatient service did not always provide safe and appropriate care. There were instances where patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Most patients found the staff caring, but care was not always responsive. Patients received treatment and follow-up appointments. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. The service had a high number of patients who did not attend their appointment and there were a high number of cancelled and delayed clinics.

Outpatients

Are outpatients services safe?

Staffing

Patients had consultation, diagnostic tests and assessment and consultations with appropriately qualified staff and advice was sought from other healthcare professionals, where necessary. However, sometimes patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Environment

Some of the outpatient services were provided in a clean, safe and accessible environment. However, staff reported to us that patients had to frequently wait in corridors.

Infection control

One hand hygiene gel was empty in outpatients. However, we observed staff always following infection control guidelines such as not having any clothes or jewellery below the elbow.

Accessibility

All clinics were on the ground floor, making access safe and easier for patients with mobility difficulties. There were wheelchairs in the outpatient areas for use if needed.

Safeguarding

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff told us that they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. The Trust had a safeguarding team if staff needed support.

Are outpatients services effective? (for example, treatment is effective)

Quality and monitoring

The Trust had recently started auditing their appointment times to ensure the time was spent efficiently and obtaining feedback from patients about their appointments. We were told that, in the first month, patient feedback had been positive and meetings with a patient representative were being held in the outpatients department.

Team working

Some staff told us that frontline staff worked as a team and staff moved between Queen's and King George hospitals if there was a shortage of staff that could not be covered.

Are outpatients services caring?

Staff attitude

Most patients told us they found the staff caring. They said staff were reassuring and explained their current treatment and next steps, including the risks and benefits. When we observed patient consultations, staff were friendly, explained the next stages of their treatment and gave patients contact details if they needed further support after they were discharged.

If a patient did not see their usual doctor, patients told us they felt the doctor was informed about their condition and background.

Information was available in all outpatient clinics informing patients of any delays and most patients told us they felt informed about appointments at both hospitals.

Information desks were available in public areas so patients could be assisted to find their outpatient appointment.

Are outpatients services responsive to people's needs? (for example, to feedback?)

Appointment times

Although patients were allocated sufficient time with staff when they attended clinics, in some clinics, this time was sometimes reduced due to delays or overbooking. A text reminder system was in place for all outpatient clinics, but staff and patients told us they had experienced some difficulties using the system. The Trust is taking action to address the problems. Staff in the outpatient area felt that call centre staff had not been adequately trained due to the amount of errors that were occurring: an average of 40 percent of appointments not being booked correctly causing more delays. Call centre staff had recently been undertaking work at the weekends to help with the introduction of a new IT system.

Outpatients

Some patients told us that appointments were sometimes delayed and staff told us delays could go up to 90 minutes for scheduled appointments. We observed patients waiting up to 50 minutes. Staff told us these delays were due to a number of factors, including consultants being scheduled to conduct ward rounds or other duties at the same time as scheduled clinics, patients and staff having to wait for parking spaces, staff travelling from other Trust sites without enough time allocated, patients not receiving appointment letters or receiving multiple appointment letters, or lost medical notes.

It was estimated that around 10 percent of medical notes were missing for each clinic, equating to around 200 a week. This was due to staff not tracking notes correctly. It was also reported that doctors completed administration work during clinics that was not linked to the clinic and this was also causing delays. At a focus group with nurses they told us that this was due to a lack of specialist doctors. Those clinics that were either directly referred to an emergency clinic by their GP or their follow up was booked directly with the consultant were less affected by these issues. An audit by the Trust in May 2013, the Chief Operating Officer and complaints data confirmed these issues were being experienced and an action plan was in place to address them, but we did not find evidence of any improvements during our visit.

Privacy and dignity

The general outpatients' areas had private consultation rooms and we observed one patient being treated with dignity and respect, including being examined in private.

Vulnerable patients and patients needing support

Staff were aware of how to support vulnerable patients, although we were told that no patient had required a chaperone as they always attended with a carer. All outpatient areas had a telephone system that enabled staff to speak to patients in up to 60 languages without an interpreter. The Trust also had an interpreter service if patients needed it.

Are outpatients services well-led?

Management

Most of the senior staff, matrons and general managers felt supported by their colleagues and their line management. Staff were briefed by senior staff in the Trust and Trust-wide messages and updates were cascaded by email and by managers or clinical leads in team meetings. The outpatient department had an item on the risk register since 2008 regarding waiting times being longer than 18 weeks for new patients. This was reviewed in 2012 and the manager who was responsible for the area was unable to tell us what was being done to reduce the risk.

Staff told us that they escalated issues and complaints to their line management and via a daily issues logbook but, other than one example regarding dictaphones, we were told nothing had been done or staff had not had any feedback. Some staff told us that they tried to contact managers when there was an issue but had been unable to get hold of them. One senior member of staff told us they were unable to be as visible as they had been previously due to a lack of staff.

Good practice and areas for improvement

Introduction

The inspection has identified many areas that require improvement notably in the domains of effectiveness and responsiveness and a few that were inadequate in the safety domain. However, one area that is a key strength is in the domain of caring.

Areas of good practice

- Areas of good practice:
- The eHandover system in the medical services which allowed doctors to manage their workload more effectively.
- The virtual ward, in medical services, which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- Patients were positive about the care they received from staff, many of whom were positive about working for the Trust.
- The inspection team was impressed with the care provided to patients who have had a stroke

Areas in need of improvement

Action the hospital **MUST** take to improve

- Areas where the hospital **MUST** improve:
- Waiting times in the A&E department must be reduced
- Increased number of permanent senior medical staff in the A&E department
- The care provided in the medical, surgical care services and end of life service
- The management of sepsis
- Discharge planning and movement of patients through the hospital to ensure patients are cared for on the appropriate wards and clinical areas and discharged when they are well enough.
- Management of the appointment times in some of the outpatient clinics
- Documentation relating to patient care.
- Sharing information to monitor performance and quality of care
- Cleanliness and infection control in operating theatres
- Job planning for consultants to enable them time to travel between the two hospitals and attend ward rounds and outpatient clinics

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities)</p> <p>Regulations 2010: Care and Welfare of Patients</p> <p>People who use the service were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by ensuring the welfare and safety of the service user.</p> <p>Improvements are needed in respect of :</p> <p>The care they receive in the A&E department and medical services</p> <p>Discharge planning and ensuring patients are cared on the appropriate wards/clinical areas</p> <p>Management of the appointment times insome of the outpatient clinics</p> <p>Regulation 9 (1)(b)(i)</p> <p>Regulation 9 (1)(b)(ii) and Regulation 9 (1)(b) (iii)</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities)</p> <p>Regulations 2010</p> <p>Records</p> <p>Improvements are needed in respect of nursing documenting all appropriate documentation relating to patient care.</p> <p>Regulation 20 (1)(a)</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulations 2010

Staffing

There were not enough qualified, skilled and experienced staff to meet the needs of patients.

There are insufficient permanent medical staff employed in the A&E department

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities)

Regulations 2010

Cleanliness and infection control

Service user were not protected from the risk of a health care associated infection because staff in the operating theatre did not follow infection

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities)

Regulations 2010

Assessing and monitoring the quality of service provision

The provider did not have effective systems in place to monitor the quality of the services provided.

Regulation 10 (1)(a) 2 (b)(i)