This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

A list of the acute hospitals at Barking, Havering and Redbridge University Hospitals NHS Trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital Romford</td>
<td>Rom Valley Way Romford Essex RM7 0AG</td>
<td>Large maternity unit including Queen’s Birth Centre, renal dialysis unit and specialist neurosciences centre</td>
<td>Barking and Dagenham, Havering, Redbridge and Brentwood.</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>Barley Lane Goodmayes Essex IG3 8YB</td>
<td>Planned care centre</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Website)
The trust provided the following trust wide information in their routine provider information request.

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) provides core hospital and specialist services from two large acute sites: Queen’s Hospital in Romford and King George Hospital in Ilford. The trust also provides services in the communities of Barking and Dagenham, Havering, Redbridge and Brentwood. The trust’s vision is ‘to provide outstanding healthcare to our community, delivered with pride.’

- The trust has 6,346 staff, with 80% in clinical care roles.
- The trust serves a population of over 800,000 across Barking and Dagenham, Havering and Redbridge, and into Essex.
- The trust provides 663,000 outpatient appointments a year.
- The trust provides services for 6,500 paediatric inpatients and 11,200 paediatric outpatients a year.
- The trust sees 274,000 emergency attendances and 55,500 emergency admissions a year.
- The trust has the third biggest maternity unit in the country and delivers 8,300 babies a year.
- The trust delivers 26,000 inpatient and 48,000 day-case procedures a year.
- The trust’s annual income is £505m.

(Source: Routine Provider Information Request (RPIR) – Context acute)
Is this organisation well-led?

Leadership

Senior leaders had the experience, capacity and capability to ensure that the vision and strategy of the organisation could be delivered and risks to performance addressed.

The trust board included executive and non-executive members with a range of experience, knowledge and skills. The executive directors comprised of an interim chief executive, chief nurse (and deputy chief executive), chief medical officer, chief operating officer, director of finance and investment (who also was responsible director of strategy and infrastructure), interim director of people and organisational development, and director of communications and engagement. The chief executive had been in post since August 2018 and was due to step down late December. The board were actively looking to recruit a suitable replacement and interim arrangements were for the chief nurse to act up in the meantime.

The interim director of people and organisational development had his contract agreed to April 2020.

There had been significant changes in the trust leadership following the previous inspection, with only the chief nurse in permanent post longer than two years. After the inspection, we were also informed that the director of finance and investment had resigned his post and would be leaving the trust in February 2020.

The non-executive directors comprised of seven individuals with various backgrounds and experience. The chair had been in post since November 2017 and also chaired the neighbouring NHS community and mental health NHS foundation trust that BHRUT worked closely with. This had allowed for more effective working and greater understanding of the challenges that the organisations faced working together.

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 50% were female.

Of the non-executive board members 20% were BME and 40% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>20.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>9.1%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

The board had overall responsibility for monitoring quality of performance and finance. The trust had been placed in to financial special measures by NHS Improvement (NHISI) in February 2018 and rated inadequate for its use of resources. At our last well led inspection in January 2018, there was concern that despite the varied experience shared by the non-executive directors, finance and accountancy experience was one area that should be strengthened, as only one non-executive director had experience as a chartered accountant.

Following the last inspection, the trust had actively sought to improve financial oversight at board level, leading to the appointment of the current interim director of finance and investment and the appointment of a non-executive director with wide experience as a chartered accountant. Further
strengthening of the finance leadership team included the recruitment of a deputy and associate director of finance. The finance team had a good understanding of the importance of effective system working and management in delivering sustainable services.

Individual responsibilities amongst the non-executive directors included chairing the Finance and Investment Committee, Audit Committee, Quality Assurance Committee, People and Culture Committee; as well as leading the Equality, Diversity and Inclusion Steering group.

At our last inspection, the non-executive directors recognised that further improvement was needed to ensure that they had sufficient oversight of organisational risks. The chair had scheduled more frequent board meetings – ten times a year instead of six – and had facilitated restructuring of governance meetings to ensure that more time was assigned to better oversight of issues. There was evidence of constructive challenge on the board which we also observed at a board meeting.

We found the senior leadership team was knowledgeable about issues and priorities affecting the quality and sustainability of services and understood what the challenges were and took appropriate and timely action to address them. The chief nurse was the executive lead for patient safety and quality and there was evidence through our core service inspections of demonstrable improvement in these areas.

The trust had a current fit and proper persons policy. We reviewed the files of all executive and non-executive directors and found they contained evidence of relevant checks to comply with the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). There was evidence of ongoing checks, and during our review of FPPR processes, the trust determined to further ensure consistency across these and amended the policy accordingly.

The senior leadership team had been working to ensure that leaders at every level were visible and approachable. At our last inspection, there was concern regarding how the senior leadership team engaged with the medical workforce. This had negatively impacted the working culture and had ultimately led to the former medical director stepping down. The current medical director was well supported by the medical workforce and this had resulted in improved engagement.

The chair encouraged an ‘open door’ approach to engagement with staff. Non-executive directors carried out ‘walk arounds’ visiting wards and clinical services and there was plans to formalise this with each director assigned to a specific directorate, although this was not yet in place at the time inspection.

The chief nurse was well respected among nursing staff who commented that she was actively engaged, approachable and had been significant in driving positive change among the nursing workforce.

However, a recent review of organisational culture supported by NHSI had identified areas among the senior leadership of the trust that warranted further development. Staff had commented that they believed more needed to be done to address the negative perceptions that the leadership were not understanding, and we found this perception still existed among some staff groups we spoke with during our core service inspections. We heard examples where some staff felt that their concerns were not being addressed and that particular members of the board were not approachable or supportive. The trust recognised that it would take time and sustained focus to address this and were committed to delivering improvement.

The clinical structure comprised six clinical divisions; each run by a clinical director, a divisional nurse and a divisional manager. The divisions reported to the board through the chief operating
The six divisions were: acute medicine, anaesthetics, cancer and clinical support (including outpatients), specialist medicine, surgery, women and child health.

The divisional directors acknowledged the progress that had been made across the organisation since the last inspection. They cited examples where there was improved and effective collaborative working with senior leaders and staff within divisions felt more empowered within their roles, although they recognised there remained areas that operated in silo. They described the significant challenges that the trust still faced across some of its services and within the culture of the organisation, however concluded that the organisation was in a better place to meet these challenges.

The interim director of finance and investment had allocated six of his most senior financial leaders to align and work with the clinical divisions. This had helped to improve financial understanding and delivery of the financial recovery plan at divisional level.

Senior leaders had been in discussion with NHS England and NHS Improvement and other stakeholders across the local sustainability and transformation partnership (STP) regarding the future direction of the trust. At the time of our inspection, the longer-term plan was for BHRUT and the neighbouring mental health and community NHS foundation trust to establish a group model of working, with one common chief executive. All board members we spoke with agreed that this was the best direction of travel for the organisation, but there was also concern expressed from some as to the inherent risks and potential impact across the organisation of introducing such a significant change and the capability of some leaders to deliver this.

**Vision and strategy**

The trust had established a clear set of values to underpin the development of organisational strategies and were developing these to align to local plans in the wider health and social care economy. Services were planned to meet the needs of the relevant population.

The trust had developed a quality improvement strategy in partnership with an external organisation in 2015, following a series of workshops, and internal and external engagement events. Called the PRIDE Way, it focused on being patient centred, with attention paid to developing the culture of the organisation and structured enabling strategies. The methodology incorporated the trust values of ‘passion, responsibility, innovation, drive and empowerment’; emphasising person-centred care and an evidence-based quality improvement culture.

At our last inspection, staff were varied in their understanding of the strategic vision and direction of the trust. They were able to talk about the direction of the service they worked in but were less likely to describe the trusts’ overall direction when asked. Senior staff were also varied in their understanding of the overall direction that the trust was heading. On this inspection, we still found uncertainty among staff we spoke to, albeit that many more cited the PRIDE Way as being significant and instrumental in driving change within the organisation.

The PRIDE Way methodology had now been a significant part of the trust identity since 2015 and was incorporated across all clinical and non-clinical areas. In comparison to our last inspection, we found demonstrable evidence of its impact and integration in to clinical and non-clinical services.

The trust had commenced a programme where the ‘top 100’ leaders of the organisation were identified to partake in the PRIDE Way leaders training so that they could each be instrumental in imparting the methodology widely across services. It was recognised that the pace of change and
impact had been slow, however there was optimism, evidenced by clear examples of how the methodology affected change.

The trust had set five key objectives for 2019/20, underpinned by 11 ‘annual goals’ which were to be further tracked through key performance indicators. The five objectives were: delivering high quality care; running our hospitals efficiently; becoming an employer of choice; managing our finances; working in partnership.

The trust had worked to create governance frameworks that were designed to ensure the effective identification, management, escalation and reporting against these objectives, as well as risks to delivery. Improvement priorities associated with these objectives were set out under three areas: patient safety, clinical effectiveness, patient experience. An executive director was aligned to have overall responsibility for each priority, with the chief medical officer and chief nurse holding responsibility of the direct clinical aspects, while operational responsibilities rested with the chief operating officer.

The organisational strategy was in development and the trust was taking appropriate steps to engage with stakeholders and staff, including making provisional plans for public consultancy when ready. The trust were ensuring that strategic development was aligned with the wider London and STP plans. The trust’s conversation regarding its vision and strategy included a broader strategic health plan for integrating community and acute services to provide a more joined-up approach to the delivery of health care across the local health economy. It was recognised that historically the relationship between primary, secondary and social care within the local boroughs the trust served had not always worked efficiently. Hence plans to ensure that the strategy considered a broader collaborative approach to delivering healthcare to the population.

There was an emergent vision of group working with the neighbouring community and mental health NHS foundation trust with whom both organisations shared a chair in common. This vision had been developed since the development of the financial recovery plan and was supported by NHS England and NHS Improvement, local commissioners and stakeholders. Consultants were working with the trust to develop a clinical strategy and underpinning enabling strategies (for example: workforce, estates, information technology) were being developed. Regular strategy development meetings were underway, although at the time of inspection there was not a clinical lead to represent and lead the development of the clinical element of the strategy. The trust were actively looking to recruit into this position.

The trust had acted to address the workforce challenges across the organisation, including recruitment and retention challenges within the nursing, midwifery and allied health professional workforce. Notwithstanding introduction of several positive initiatives, such as the school of surgery, the emergency department academy and priority action to recruit and retain a flexible and diverse workforce, the trust was still developing its workforce strategy.

The trust was placed into financial special measures in February 2018. A financial recovery plan with NHSI had been agreed in December 2018 that set out clear trajectories for financial improvement over the two financial years 2019-20 and 2020-21. The plan was clearly owned and signed-off by the executive directors and clinical leaders of the trust. The trust acknowledged that recurrent plan delivery was likely to take longer than expected and we were told that three or more years to deliver the changes outlined in the plan was more realistic.
Culture

Senior leaders predominantly modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. However, despite improvements, staff satisfaction was mixed, and some staff groups did not always feel actively engaged or empowered.

At our previous inspection we found improvements needed to be made in engaging with the consultant body. This included improvements in communication, bettering opportunities for involvement in the organisational strategy and changes to services, development and learning, and consideration of health and well-being at work, such as flexible working. On this inspection we found improved engagement between senior leaders and the consultant body and were given examples of collaborative working, particularly in areas where staff had not always got on or worked well together. However, we still heard a few accounts of where consultants were uncooperative or resistant to the changes implemented by the trust.

The trust employed a diverse workforce and provided services to a diverse population with a complex demography. Senior leaders were committed to seeing lasting improvement in organisational culture and inclusive staff engagement and empowerment, although they recognised that this was going to take a lot longer to achieve than had been previously hoped. Consequentially, senior staff were more aware of the issues and more realistic to the challenges it posed. The trust had embarked on a cultural change programme with the support of NHSI that had helped diagnose the fundamental issues affecting organisational culture, recognising the relationship between positive staff engagement, quality of care, patient experience and overall organisational performance.

The recent NHS staff survey had highlighted several areas of concern. These included: concerns about some leadership behaviour; opinion that the organisation’s vision could be improved; experiences of poor behaviour which is often highlighted as bullying; high stress and pressure environment; time to do their role and lack of resources; staff belief and engagement in change.

The following illustration shows how this provider compares with other similar providers on ten key themes from the NHS staff survey. Possible scores range from one to ten – a higher score indicates a better result.
There were no themes where the trust’s scores were significantly higher (better) when compared to the 2017 staff survey.

The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity and inclusion, Health and wellbeing, Quality of care, Safe environment – bullying and harassment, safety culture.

(Source: NHS Staff Survey 2018)

Other concerns raised by staff were that work life balance was negatively impacting health and wellbeing. A higher proportion of staff stated that quality of care and a safety culture was at risk. Despite the trust actively prioritising engagement and development for Black and Minority Ethnic (BME) staff, the staff survey showed deterioration in key metrics relating to equality, diversity and inclusion.

The trust provided the following breakdowns of medical, nursing and qualified allied health professional staff by ethnic group.
<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator 1</th>
<th>Indicator 2</th>
<th>Indicator 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>33.8%</td>
<td>43.4%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.4%</td>
<td>2.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>41.9%</td>
<td>12.0%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Black</td>
<td>9.5%</td>
<td>28.5%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2.2%</td>
<td>0.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other</td>
<td>9.3%</td>
<td>13.2%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Unknown / Not stated</td>
<td>33.8%</td>
<td>43.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of White and BME staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:
- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.
As of 2018, three of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (4.3% of BME staff compared to 9.1% of White staff). This remained similar to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (15.6% of BME staff compared to 25.5% of White staff). This remained similar to the previous year, 2017.

3. In 2018, BME staff were significantly more likely than White staff to be disciplined (0.9% of BME staff compared to 0.4% of White staff) when compared to White staff. This remained similar to the previous year, 2017. This indicator looks at the relative likelihood of staff entering the formal disciplinary process, as measured by the start of a formal disciplinary investigation.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

7. In 2018, 61.8% of BME staff believed that the trust provided equal opportunities for career progression and promotion which was significantly lower when compared to 74.9% of White
The score had decreased by 6.2 when compared to the previous year, 2017.

8. In 2018, 18.6% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 11.5% of White staff. The score remained similar to the previous year, 2017.

There were three BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

The trust appointed a head of inclusion in 2016. This individual worked closely with the associate director of organisational development who in turn reported directly to the interim executive director of people and organisational development. The priority was to review how culture in the organisation could be transformed. It was recognised that this would take time, however several actions had been progressed, such as improving engagement with staff networks (BME staff, LGBT+, ability network), promoting equality and diversity across the trust, developing staff and leadership development (including the INSPIRE development programme for BME staff), improving engagement with staff and generally increasing awareness at board of the challenges that minority groups face within the organisation.

Most staff we spoke with recognised the efforts that had been made since the previous inspection to promote staff inclusion, although both staff and leaders also recognised that much more needed to be done. There was evidence that the trust was expanding its focus on addressing equality and diversity matters. Priority was given to its promotion during staff induction and the inclusion team were considering how to improve the appraisal process for staff and make it more holistic.

Despite these initiatives, a significant number of BME staff spoke to us of their perception that opportunities for BME staff remained limited within the organisation and the pace of change was too slow. There was also perception that a blame culture still existed, and examples were given where staff were not comfortable in speaking up or had not been taken seriously. HR processes were deemed slow in resolving situations and opinion was given that some senior staff were bias against BME staff.

The trust had processes in place for staff to speak up. A Freedom to speak up (whistleblowing) Policy was available for all staff to access and it was encouraged for staff to raise their concerns via line managers and through HR and grievance processes if necessary.

At our previous inspection, we were not assured that staff were sufficiently confident and empowered to speak up. The Freedom to Speak Up Guardian service (FTSUG) was outsourced and was overseen by the head of inclusion (who was also the lead for HR policy). There were two staff appointed as ‘guardians on the ground’ to help raise awareness and be accessible points of contact.

FTSUG carried out a survey that highlighted that approximately 75% of staff were aware of the service which the trust recognised was not considered sufficient. Staff expressed to us that they were not confident in the service’s effectiveness in addressing issues, expressing reluctance to use the service.

FTSUG reported themes to board, the majority of which were related to bullying and harassment. Staff working in corporate services were more likely to use the FTSUG and this correlated with similar concerns expressed via the NHS staff survey. The board were confident in the service but
recognised that more needed to be done to encourage staff to feel empowered to speak up. People and organisational development were working with the guardians to develop a ‘respect for people’s behaviours’ framework that was intended to be published soon.

The Patient Friends and Family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 92.6% and 95.8% from June 2017 to May 2019. The data shows a shift, which is an indication of change.

![Graph showing response rate from June 2017 to May 2019](image)

**Barking Havering and Redbridge University Hospitals NHS Trust – response rate June 2017 to May 2019**

(Source: Friends and Family Test)

Data provided by the trust showed that sickness absence levels from April 2018 to March 2019 were below the England average, as shown in the graph below. However, core service data provided by the trust showed that sickness levels amongst nursing staff in individual core services was at times much higher at approximately 20%.

![Graph showing sickness absence levels](image)
In the 2018 General Medical Council Survey the trust performed worse than expected for six indicators (shown below) and the same as expected for the remaining 12 indicators.

(Source: General Medical Council National Training Scheme Survey)

A junior doctors forum was set up and met regularly. Historically, there had been poor attendance, but this had improved. Junior doctors we spoke with had mixed opinion as to the support and morale across the organisation, with some areas highlighted as being better and more supporting.

Supervision and education were seen as varied across clinical areas. It was considered by some that it was necessary for greater emphasis on effectively promoting, in a more meaningful way, the NHSI ‘Eight high impact actions to improve the working environment for junior doctors.'
An interim guardian of safe working hours met regularly with the chief medical officer. Attention had been made to improving the rota for trainee doctors, removing gaps and addressing any issues that were highlighted in exception reporting. Initial review had highlighted areas for development and the chief medical officer was committed to addressing these. However, we heard from some junior doctors that in some clinical areas, exception reporting was discouraged, with clinical leads preferring to address issues associated with rotas and working longer hours individually.

Despite the cultural challenges, there were several examples highlighted during our core service inspections of strong collaborative working, with staff expressing pride at what they do and for the teams they worked within. Example being the high morale we found among the end of life care multidisciplinary team which was reflected in the outstanding leadership of the service; and the confidence that urgent and emergency care staff had in the service leadership team to support staff in providing the best possible care.

Several nursing staff were able to give examples of how they felt supported despite such issues referenced in the NHS staff survey - such as challenged work life balance - and were able to describe how the culture within the organisation had moved on since the last inspection. Some staff positively attributed this to a more effective and stable senior leadership.

Governance

The board and other levels of governance within the organisation predominantly function effectively and interact with each other appropriately. The trust recognised it needed to improve governance processes to enable effective oversight and management of safety and performance within the outpatients service.

The trust had a comprehensive committee structure consisting of the Quality Assurance Committee (QAC), the Finance and Investment Committee (FIC), the Audit Committee, the Trust Executive Committee and the People and Culture Committee. The lead board committee for quality and safety was the QAC. Chaired by a non-executive director, the committee met every other month and was responsible for reviewing key quality performance indicators. The risk and compliance group and the quality governance steering group informed the key quality risks and concerns that were reviewed at the QAC. The chair of the QAC also attended the Audit Committee, representing quality issues along with the chief nurse who was the executive lead for quality and safety.

Divisional data gathered into dashboards had been aligned with CQC domains making the data gathered clear and accessible. Red, amber, green (RAG) rating was in place to help evaluate priorities, and progress and trends were visible, although it was recognised that further improvement in evaluating trends and benchmarking would benefit. Exception reporting from divisional teams was in place, and key risks and concerns identified at QAC were then represented at board.

At ward level, daily ‘huddles’ with staff were routine and allowed for discussion of relevant issues and incidents. Weekly clinical governance meetings at service level took place to discuss serious incidents and other departmental issues. The clinical governance meetings fed into weekly divisional meetings. There were also monthly divisional quality safety meetings where items such as national audits, evidenced based guidelines and complaints were discussed. Our core service inspections found these lines of governance had improved oversight and communication with staff, however there remained occasions where learning was not effectively shared, in particular across core services.
The chief nurse, in her role as executive lead for quality and safety, was supported by four deputy directors of nursing, one of whom was specific lead for patient safety and quality. Board members commented that there was improved oversight of quality and safety issues within the trust and improved assurance that risks were addressed and mitigated.

Governance processes for the oversight of patients waiting for follow-up appointments (non-RTT pathways) did not provide effective oversight. Responsibility for these patients sat with the individual speciality teams and was not centralised, hence the trust lacked a standardised process across speciality departments to ensure patients were regularly reviewed for risk of harm or deterioration as a result of waiting for treatment. The trust recognised this as an area for improvement and had begun work to standardise this process which was due for completion end of December 2019. Whilst we acknowledged the trust had a plan in place to address this risk, the pace of improvement had been slow and the current governance processes did not provide effective oversight of waiting time performance.

Financial governance and performance management had been strengthened following the last inspection. The trust had also undertaken external reviews of their financial governance and the trust were confident that all recommendations had been actioned. The current executive director of finance and investment was a significant addition to the board. Likewise, the appointment of a non-executive director with a background as a chartered account provided further financial challenge and oversight and chaired the Finance and Investment Committee (FIC).

The FIC had oversight of all financial decisions in the trust and focussed on detailed financial governance and recovery plan delivery, including cash management and consideration of business cases. This included reviewing cash flow and creditor payment performance monthly with the board. We were told that the trust was maintaining the levels of cash balances required by its regulators. However, the external auditor had identified a risk relating to loan repayment by the trust which had been outstanding for more than 12 months. This risk was identified on the corporate risk register however, it was not clear as to the current action plans to address this.

We attended a board meeting and witnessed collaborative discussion and where appropriate, challenge from non-executive directors. The board had begun to meet monthly following the appointment of the current chair, this was effective in ensuring that matters were better addressed in a timely way. Papers for board meetings were presented as an integrated report. Committee chairs commented that improvements had been made to the quality of the report and the detail was clearer and more appropriate. Committee minutes were also of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility.

The Audit Committee, chaired by a non-executive director, was responsible for reviewing the trust risk register, Board Assurance Framework (BAF), scrutinising changes and ensuring appropriate controls were in place and what gaps in controls needed addressing.

The trust provided their BAF, which detailed five corporate objectives and accompanying objectives.

A summary of these is below:

1. **Delivering high quality care**
   a. Achieving a CQC ‘Good’ rating for caring, safe, effective and responsive.
   b. Improve medicines management and implement quality account priorities.

2. **Running our hospitals efficiently**
   a. Deliver agreed trajectories for emergency care, planned care and diagnostics.
3. **Becoming an employer of choice**  
a. Improve percentage of staff rating the trust as ‘a good place to work’ from 53% to 56%.  
b. Reduce vacancy rates from 13% to 11%.  
c. Improve equality, diversity, inclusion (EDI) score from 8.3 to 8.5.  

4. **Managing our finances**  
a. Reduce underlying deficit from £65m to £51m, including £28m of savings within the trust.  

5. **Working in partnership**  
a. Transform care pathways across our ISC for patients + £10m financial benefit from the 50:50 partnership with CCG.  
b. Complete a feasibility study for an ICS Academy & Innovation Centre.  


The structure of the BAF had been further developed since the last inspection and was clear and easy to understand. Operation of the BAF was outlined within the risk management strategy that had been signed off by the board, having first been reviewed by the Audit Committee. Review of the BAF was a standard item at board meetings. The board reviewed all strategic risks pertinent to each specific strategic objective using a rolling programme over the year.

Before being presented at board, the BAF was scrutinised at the Trust Executive Committee by executive and non-executive directors. The Audit Committee maintained oversight by reviewing the BAF (and the corporate risk register) twice a year. Board members were clear as to the strategic risks of the organisation and clearly recognised the challenges.

### Management of risk, issues and performance

The trust had in place systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we found that identifying and sharing learning from incidents was not always effective or consistent.

The trust had a structured governance approach to reviewing risks within the organisation. Local risk registers included all risks related to the service and informed divisional risk registers. Risks were reported on the trust-wide risk register and high-level risk registers (containing risks scoring 15 and above) were monitored via the quality governance steering groups and divisional quality and safety groups. Strategic risks, which prevent the trust from achieving corporate objectives, were recorded on the BAF which was monitored at board. At board sub-committee level, risk management was managed via the risk and compliance group, chaired by the chief operating officer, which undertook scrutiny of risk management at division and specialty level. Risks that aligned to the specific board committees were then escalated accordingly.

The trust provided a document detailing their 11 highest profile risks. The five shown below, taken from the document, show those with a current risk score of 20 or higher.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk references from corporate</th>
<th>Description</th>
<th>Risk score</th>
<th>Risk level</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td></td>
<td>risk register</td>
<td>(current)</td>
<td>(target)</td>
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</tr>
<tr>
<td>4.2</td>
<td>1134, 1287</td>
<td>Failure to secure capital funding to allow the Trust to deliver the Financial Recovery Plan and operate from/with a fit for purpose asset base</td>
<td>25</td>
<td>20</td>
<td>Nov 2019</td>
</tr>
<tr>
<td>4.1</td>
<td>1133, 1137, 1134, 1286</td>
<td>Inability to sustainably deliver Income and Expenditure Financial Recovery, and £28m gross savings</td>
<td>20</td>
<td>25</td>
<td>Nov 2019</td>
</tr>
<tr>
<td>2.2</td>
<td>290, 882, 1097, 941, 1163, 1028, 421, 916, 1097, 1245</td>
<td>Failure to deliver the Constitutional Standards and other key operational targets will have detrimental consequences, such as impact on patients, reputational loss and contractual fining.</td>
<td>20</td>
<td>15</td>
<td>Sept 2019</td>
</tr>
<tr>
<td>3.1</td>
<td>1071</td>
<td>Not being able to embed an appropriate high-performing culture throughout the whole Trust</td>
<td>20</td>
<td>12</td>
<td>Oct 2019</td>
</tr>
<tr>
<td>3.2</td>
<td>1015, 991, 1033, 1071, 823, 1060, 853, 1229</td>
<td>Failure to recruit and retain appropriate numbers of permanent, capable staff to deliver the operational plan.</td>
<td>20</td>
<td>12</td>
<td>Oct 2019</td>
</tr>
</tbody>
</table>


Senior leaders were more assured of the quality of risk reporting and there was greater confidence in the oversight of safety and quality within the organisation.

The main risk to the organisation discussed by senior leaders was the financial recovery plan and its subsequent impact on delivering strategic goals. Since the last inspection, the trust had made significant progress in strengthening financial governance, increasing financial grip and control, and engaging the wider organisation in driving the necessary financial improvement.

At the previous inspection in 2018, where NHSI carried out a review of the trust’s use of resources, it was evident that due to poor financial control the trust had rapidly ran out of cash to pay its suppliers and maintain its essential services in October 2017. Two external reviews into financial governance were commissioned and reported in 2018, which made recommendations for improvements. The trust has since implemented the recommended improvements to its financial controls and includes reporting of its cash and working capital position and forecasts in monthly reports to the finance and investment committee and board reports.

For the current financial year 2019-20, the trust had a planned turnover of £607.7m and had accepted its financial control total of a deficit of £55.1m before provider support funding. At month five, the trust reported a deficit of £20.5m, £0.2m behind plan. To achieve this financial performance, it had benefitted from £4.2m of one-off savings; and, excluding these one-off items, it assessed at the end of August 2019 that it was incurring a monthly cash shortfall from normal operations of £4.9m, compared with the plan of £4m / month. The trust was currently forecasting that it would achieve its financial control for 2019-20, albeit supported by one-off measures.
Concerns remain about the ability of the trust to deliver savings at the level required to meet its planned financial recovery trajectory, and a three or more-year trajectory had been cited as more realistic and likely.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£572.1m</td>
<td>£550.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£49.0m</td>
<td>£60.3m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£523.1m</td>
<td>£489.9m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£1.4m</td>
<td>(£52.5m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Senior leaders and stakeholders agreed that aside to the financial concerns there remained the challenge of meeting NHS constitutional standards in the emergency department (ED). The Department of Health’s standard for ED is that 95% of patients should be admitted, transferred or discharged within four hours of arrival. From July 2018 to June 2019, the trust did not meet the standard and performed worse than the England average. The average percentage of patients admitted, transferred, or discharged within four hours at the trust was 80% compared to the England average of 87%.

Senior staff told us that admitting, transferring or discharging 80% of patients within four hours across their emergency departments was considered a good achievement in view of the circumstances faced by the service. For example, the number of patients attending the emergency departments daily had on occasion far exceeded the designed capacity at both King George Hospital and Queens Hospital and demand was increasing. There were multifaceted systems challenges within the local health economy that added to the pressure upon the service at both hospitals. We heard from senior leaders, commissioners and stakeholders as to how relationships had improved between primary care and the trust with greater transformational approach to addressing the challenges collaboratively. However, the leadership team within ED had also raised with senior leaders at the trust their concern of the lack of shared ownership by divisional teams of the ongoing challenges within ED, and that this was also a factor influencing effective performance within the service.

The trust was taking steps to improve the organisational culture as outlined above and it was recognised that this would need considerably more time to address than had been anticipated. Over 100 overseas nurses were scheduled to start work at the trust this winter which was a big step to addressing the recruitment gaps within the nursing workforce.

The trust’s risk register also included five risks which related to waiting time performance, delays to patient care and the impact of problems within IT systems. These were rated as high, with one rated extreme that related to workforce capacity to manage the patient pathway to discharge. Controls had been identified to mitigate these risks, which included establishing an overarching steering group to oversee the multiple SIs, and introducing systems to track patient pathway, validation, clinical review and harm review process.

In accordance with the Serious Incident Framework 2015, the trust reported 133 serious incidents (SIs) which met the reporting criteria set by NHS England between May 2018 and Apr 2019.
During the reporting period, medical care had the highest number of STEIS reported incidents at 38 followed by urgent and emergency care (27 incidents), maternity (10 incidents) and surgery (8 incidents). The majority of SIs in medical care were related to pressure ulcers and falls, some of which had resulted in fractures. There were also seven SIs regarding information governance and seven IT related SIs predominantly relating to patient communication, that potentially impacted patient care (refer to Information management section below).

All incidents were reported on the trust’s risk management database. The quality and safety team reviewed all incidents daily. Serious incidents (SIs) were identified and then disseminated to the relevant division which would triage the SI and a process of investigation would commence, starting with a round table conversation to discuss the incident. This would include a review of immediate actions taken and consideration of duty of candour.

A SI working group (SIG) met weekly to review all SIs and associated investigations. Those identified to lead on SIs within each directorate were invited to feedback on their learning. The SIG monitored completion of actions identified during the investigation process. Themes and outcomes from SIs were part of the integrated report that was presented to board.

Since our last inspection, the trust had identified areas for improvement. The head of quality had taken initiative to introduce a video learning tool on the intranet to help staff better understand the process, and there was recognition that both the timeliness and quality of investigation needed to improve, and the trust had taken steps to address these. The trust acknowledged that improvement with cross-divisional learning remained an area for improvement. The server that managed the software platform was also due to be upgraded and would enable improved access to data.

Specific time frames were in place to respond to an SI and initiate action and a root cause analysis investigation (RCA): 48 hours to add SI to STEIS; 20 days for a draft report to be prepared; 35 days for divisional teams to agree and sign off report.

A meeting chaired by the medical director convened weekly to review final reports and ensure quality. Reports were then to be submitted to the clinical commissioning group (CCG) by 60 days. In line with the duty of candour, a verbal apology was to be given within 48 hours and a written apology provided within 10 working days.

We reviewed eight SI reports that the trust provided and noted that they were clearly laid out and easy to read and understand. Each report included a summary of the basic facts and findings. There was evidence that investigations were expertly led and credible and carried out in collaboration with others as necessary. We saw evidence that staff were invited to round table discussions and steps were taken to engage patients and family. There was a focus on identifying areas for improvement and learning. Action plans and identified learning were predominantly detailed, with completion of actions clearly dated.

We also reviewed SIs as part of our core service inspection and found examples of delays in investigating some SIs, including the time taken to complete root cause analysis (RCA). We found example where learning from SIs was not always shared effectively. For example, the trust had reported multiple SIs in the 12 months prior to our inspection which impacted on many patients waiting for outpatients appointments. However, most staff were unaware of these incidents.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
The trust reported three never events between May 2018 and Apr 2019. Two never events related to the unintentional connection of a patient requiring oxygen to an air flowmeter. One never event related to the retaining of a nasogastric tube guidewire (retained foreign object). All the never events that occurred had been investigated and detailed actions to prevent recurrence where shared with staff.

Another never event reported in May 2019 occurred in critical care that concerned a retained guidewire that had been detected six weeks following a central venous catheter insertion. We had concern as to the learning and communication of the action points from this incident and the time taken to revise the checklist for insertion which was still not completed by the time of our inspection in September.

National safety alerts are issued via the Central Alerting System (CAS), a web based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations. The trust had in place a CAS alerts officer supported by an administrator and was responsible for ensuring CAS alerts were effectively shared across the organisation.

Medicines incidents were reviewed in the safe medicines practice group that informed the medicines optimisation group. A key risk to medicines management was the lack of electronic prescribing. However, this had been agreed at board to be critical and plans to implement this were underway.

The trust information technology (IT) infrastructure was not cited on the risk register as having a score of 20 or above, however senior leaders expressed concern at the level of underfunding that IT had received in recent years and the cost to address this exceeded the planned budget. Core elements of IT, such as hardware and software licences, were at the end of their life cycle and would need to be updated in the coming 12 to 18 months. The trust had appointed a ‘joint’ director of information management & technology (IM&T) to tackle this issue who also had a substantive position as director for IM&T working for the neighbouring community and mental health NHS foundation trust.

The trust participated in mandatory national clinical audits conducted by the Healthcare Quality Improvement Partnership (HQIP) as well as national confidential enquiries the trust was eligible to participate in. The trust also undertook local clinical and non-clinical audits with a view to improving care and efficiency. In 2018/19, the trust participated in 230 local clinical audits, some of which were initiated following a service complaint, clinical incident or risk management concern. Local clinical audits are important in identifying actions to improve quality of care.

There were plans in place for emergencies. The trust had a business continuity plan to ensure the trust could respond to business continuity incidents and was able to continue to operate essential services at an acceptable pre-defined and agreed level. There were current major incident plans for both acute hospital sites. The plans identified key members of staff and detailed their roles and responsibilities.

Information management

The trust collected and analysed information through the use of key performance indicators and other metrics. It was recognised that there was a need to improve the overall IT infrastructure. There had been significant incidents concerning communication with patients and information governance.
Quality and safety dashboards provided key performance data that was collated at service level and enabled clinical staff to monitor activity and clinical outcomes. Divisional meetings reviewed data and exception reporting allowed for significant concerns to be escalated through the divisional and committee structures, informing the board assurance framework.

Board papers were compiled into an integrated report. These were comprehensive, and with the board now meeting monthly, allowed for more frequent review of significant matters. The Audit Committee was responsible for ensuring the quality of data presented to the board. Non-executive directors confirmed the overall improvement in the quality and accuracy of data now presented to board. We saw evidence in the integrated report where board committees reported to the board (in the public domain) and although committee papers were not always available there was reported discussion within the board minutes.

The trust had significantly improved financial divisional data that was collated into monthly reports and then presented to board. Getting It Right First Time (GIRFT) and model hospital data was used to drive understanding of and commitment to transformation and financial recovery.

The trust’s data quality was subject to assessment against national and regional dashboards. At the time of our inspection, the trust was performing well against other London NHS trusts. The organisation promoted a vision to be one of the best data quality NHS trusts in London. The director for IM&T oversaw the digital quality team and was clear as to the challenges the trust faced regarding information management.

The trust had in place a senior information risk officer (SIRO) who was responsible for overseeing the management of information risks and incidents within the organisation. The interim director of finance & investment held this responsibility. A Caldicott Guardian was also in place who was responsible for the management of patient information.

The trust used paper patient records and senior staff we spoke with expressed the inherent risks of this and the need for the trust to move to electronic records, although the cost of upgrading this along with the IT infrastructure was considerable and a commitment to this was yet to be made. We found examples during our core service inspections where patient records were not always stored securely.

There were several different IT systems used across clinical services which, in an example noted in urgent and emergency services, made it hard for clinicians to see the full patient picture, this remained an issue since our last inspection. The current interim director of IM&T was driving plans to improve connectivity and use of technology across the trust; for example, improving wi-fi and access to mobile diagnostic software. These were deemed positive changes despite the need for a larger overhaul of IT across the organisation.

Following the previous inspection, the trust had resumed national reporting of referral to treatment times (RTT) and had a dedicated team who validated and audited RTT pathways, as well as provided RTT training to all levels of hospital staff. Although the trust had agreed an improvement plan with their commissioners with the aim of reducing the number of patients on their waiting list and improving RTT performance, this was not being achieved and the trust’s overall RTT performance had declined.

The trust were made aware of seven significant incidents that affected RTT and non-RTT pathways and had reviewed their governance processes to address these, seeking advice from an external consultancy. This also included a process of risk assessing patients who were waiting longer than planned to be seen and then carrying out a clinical harm review of a sample number of patients. The trust were on a trajectory to have reviewed the probability of harm of all patient cohorts on
elective pathways by end of December this year. Although there was expectation that patients on the pain pathway would likely take longer to review.

One example incident involved the system that the patient tracking list (PTL) utilised. An error was found within the software that when triggered potentially delayed the treatment time for some patients. Over 1000 patients were originally affected by this. The trust had identified the cause and were tracking the patients concerned to ensure that they did not breach their care.

There was an information governance incident in April 2018 involving patient identifying data for 182 patients being shared with an external consultancy firm. The trust had investigated this and acted to prevent recurrence. However, in June 2018 there was a further incident involving the sharing of patient identifiable data for 2,358 patients being shared to an incorrect email address. Another incident had resulted in a significant number of letters (43,000) not being sent and a further incident ascertained that 119 patients did not receive a follow up letter reminding them of their appointment and were subsequently marked on the trust system as ‘did not arrive’ (DNA). The trust had comprehensively investigated this, addressed the fault and were preparing to send apology letters (to fulfil duty of candour). The trust recognised that for some patients this may have affected their care.

After the inspection, we were made aware of another information governance incident involving patient information being sent to an incorrect address which we raised as concern with the trust.

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian’s 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. The trust’s published status as of March 2019 was ‘standards met’.

CQC had raised concern with the trust as to the validity of the 62-day cancer RTT data it presented to board and subsequently in the public domain. The trust initiated an external review of this and was to present its findings and recommendations to the board in the coming weeks following our inspection. We were told that initial conclusions had not identified malpractice, although areas for improvement were recognised.

Computer terminals in clinical areas were available for staff to access the intranet, although some staff complained that it was slow and was not easy to navigate, or that there were not enough computer terminals to allow for easy access. Staff raised concern at the continued use of paper records - when many other trusts had moved to electronic records – and gave examples when access to patient records was delayed.

Engagement

The trust had in place structured processes to communicate to staff and engage with people who use services and their representatives. However, there were examples of where staff engagement needed to improve.

Relationships with local stakeholders and commissioners had improved and there was more effective collaborative working.

The trust intranet and website were used to provide up to date information for staff, patients and carers and was the primary tool for ensuring that staff had access to the most up to date policies and operating procedures. Trust social media accounts had been set up, and there was liaison with local
media to publicise the latest trust news and developments. Wards and divisions had established regular team briefs for their staff.

Staff networks that promoted equality and inclusion met regularly monthly. These included BME staff network, LGBT+ staff network, ability staff network. An executive lead on the board was assigned to each network to help improve promotion and oversight of issues at board. Recognising the cultural challenges, the trust made steps to improve engagement with staff, including focus groups and staff surveys that helped to better understand some of the root causes. However, it was evident from staff opinion that was shared with CQC that more work and time needed to be taken to address the perceived lack of engagement and empowerment that some staff felt.

Senior leaders and staff side and trade union representatives had come in to conflict following changes that were being introduced in the pathology department that not all staff were agreeing to. Representatives expressed concern that senior leaders had not engaged adequately and had been dismissive of the concerns that they raised on behalf of staff colleagues. It was evident that the situation remained unresolved at the time of our inspection, and we were told that communication between both parties remained fraught, despite both parties taking steps to address this.

Doctors in training shared mixed experiences about the training and education opportunities during their time at the trust. A Health Education England (HEE) improvement action plan was in place following previous HEE reviews and the GMC training survey results 2018. The trust objective was to ensure that they provided a safe and enjoyable learning environment for trainee doctors and met all the mandatory requirements set out by HEE. Following a visit to the trust in April, HEE issued nine mandatory improvement requirements. As a result, the GMC placed the trust in a period of enhanced monitoring, overseen by HEE.

The trust patient experience and engagement assurance group (PEEAG), which was attended by senior and divisional leaders, clinical staff, volunteers and patient partners, met bi-monthly. The PEEAG enabled the quality governance steering group to obtain assurance that services were patient focused and supported by adequate patient experience structures. This group was well attended and comprehensively reviewed patient experience issues and concerns across all services and generated an action log for improvements that was reviewed at each meeting.

The maternity service at Queens Hospital was one of the busiest in the country and service leaders met and collaborated with other maternity teams within the London network. The Maternity Voices Partnership met monthly with women who used maternity services, commissioners and associated service providers and encouraged contribution from all parties to help identify and drive improvements within the service.

The trust met with Healthwatch every other month. Healthwatch conducted ‘enter and view’ visits to services at the trust. The last visit was in 2018, when Healthwatch visited maternity and women’s health services at Queens Hospital. The trust invited Healthwatch to undertake further reviews of patient services, the most recent being a review of how the trust were delivering the Accessible Information Standard to patients which was planned to take place between October to December 2019.

BHRUT and the neighbouring community and mental health NHS foundation trust had a common chair and since the last inspection steps had been made for closer collaborative working. As part of the wider sustainability and transformation partnership (STP) both trusts were in conversation with NHS England and NHS Improvement, commissioners and other stakeholders with a view to establishing a group model of working. With the current interim chief executive stepping down at the
end of December, there was plans to appoint another interim. However, the longer-term vision was to appoint a single joint chief executive to oversee the group model once it was established. All parties recognised that a lot of planning and work needed to be done to allow for this, however there was a positive impetus expressed by commissioners and stakeholders we spoke to that the ambition for partnership working would be achievable with the current leadership team. There had been significant improvement in how all parties were now engaging and working towards an agreed goal.

Learning, continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels of the organisation. Quality improvement methodology was encouraged and becoming more embedded across the organisation.

The trust recognised that initial steps to embed the PRIDE Way methodology in to the culture of the organisation had not been as successful as they had hoped. However, the organisation was beginning to see this positively impact learning and improvement across the organisation with a focus on patient safety, experience and improved clinical outcomes.

At our previous inspection we found low levels of engagement with the PRIDE Way methodology. However, on this occasion we found staff were overall better engaged and enthusiastic, appreciating how it was a tool for driving improvement. We heard examples of where staff who had previously not worked well together were now working collaboratively. A recent workshop had been set up to identify improvements across the outpatients service and had been instrumental in fostering a multidisciplinary approach to identifying future development of the service.

The methodology underpinned the quality improvement framework. An initiative to ensure the ‘top 100’ leaders of the organisation had completed the PRIDE Way leaders training had almost been completed with a view to ensuring the methodology could then be more widely imparted and accessible across the organisation.

The trust continued to face challenges in meeting the four-hour A&E constitutional standard; however, by adopting the NHSI ‘Red2Green’ initiative, the trust was working with partners across the system to identify ways to improve performance and reduce patient ‘bed days’ in hospital and this was having a positive impact, evidenced by improved patient flow.

Staffing and recruitment challenges were being tackled by the development of a workforce strategy. Although this was not ratified at the time of our inspection, initiatives had been rolled out to improve retention among existing staff. Recognising the physical and emotional challenge of being a newly recruited health care professional, three experienced nurses had been enlisted to provide mentoring and coaching support for newly qualified nurses, allied health professionals and junior doctors. This was the first scheme of its kind in the country and received national recognition.

The trust had also introduced the nursing associate role to the organisation which was proving very successful. The role is designed to help bridge the gap between health and care assistants and registered nurses. It is a stand-alone role that provides a progression route into graduate level nursing, allowing individuals who would otherwise not be able to access traditional academic pathways to work towards becoming a qualified nurse. Seventy trainee nursing associates were presently employed by the trust, across several specialities which had significantly improved staffing levels across services.
Within urgent and emergency services, the trust part-met the challenges of recruiting middle-grade doctors by introducing Advanced Nurse Practitioner (ANP) and Advanced Clinical Practitioner (ACP) roles. ANPs are registered nurses who have done extra training and academic qualifications to be able to examine, assess, make diagnoses, treat, prescribe and make referrals for patients who present with undiagnosed/undifferentiated problems. ACPs are allied health professionals (AHPs) who undertake similar training.

The department’s ANP and ACP programmes had received national recognition and accreditation through a local university and at the time of our inspection, there were four ANPs and one ACP working in the urgent and emergency service.

The trust was further acknowledged nationally for its commitment to carbon reduction and the organisations ‘sustainability team’ had received two national sustainability awards.

The trust’s speech and language therapy team travelled to Cambodia earlier this year providing training to health care workers managing patients with tracheostomies and swallowing difficulties.

Despite the IT challenges and associated risks, the interim director of IM&T was finding novel ways to address the issues whilst awaiting release of capital funding.

The outpatient service had developed a ‘transformation’ plan using the PRIDE Way and through a process of engagement with staff, patients and stakeholders, with a view to increasing capacity and reducing waiting times and the demand on the service. Plans included introducing virtual clinics and enhancing triaging processes to reduce inappropriate referrals. These processes were being piloted within some specialities and had already proven successful; however, additional funding and resources were required to expand this into other areas.

The outpatient service had a dedicated ‘patient partner’ who was also a trust volunteer. Their role was to act as the voice of the patient and represent patient views at a range of trust meetings and forums.

The trust had systems in place to ensure staff were recognised for their hard work and achievements. There were weekly ‘team of the week’ awards, ‘star of the month’, and an annual ‘PRIDE’ awards event.

At the time of our inspection, there was an emergent vision of group working with the neighbouring community and mental health NHS foundation trust. There was a shared enthusiasm and the two organisations were beginning to develop closer working ties, sharing learning and experience.

From May 2018 to April 2019, the trust received a total of 67 compliments. The highest number of compliments were for urgent and emergency care, with 73.1% of total compliments, followed by medical care (17.9% of compliments) followed by surgery (4.5%).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>49</td>
<td>73.1%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>12</td>
<td>17.9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>3</td>
<td>4.5%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1</td>
<td>1.5%</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
The trust commented on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>Between 25 and 60 days</td>
<td>89%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Up to 60 days</td>
<td></td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,421 (April 2018 to March 2019)</td>
<td></td>
</tr>
</tbody>
</table>

From April 2018 to March 2019, the trust received a total of 1,034 complaints. The highest number of complaints were for medical care, with 32.6% of total complaints, followed by urgent and emergency care and surgery (both 21.2%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>337</td>
<td>32.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>219</td>
<td>21.2%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>219</td>
<td>21.2%</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
<td>7.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>67</td>
<td>6.5%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>45</td>
<td>4.4%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>37</td>
<td>3.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>25</td>
<td>2.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>8</td>
<td>0.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,034</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust complaints team was overseen by the head of complaints, PALS and family liaison. Her team was supported by a senior complaints officer, two complaints officers and an administrator.

An acknowledgment letter was sent within 3 working days of receipt which the trust’s response time was 100%. The letter outlined the process and identified who would be co-ordinating the complaint on the complainant’s behalf. The trust set a time of 30 days to provide the complainant a response and current performance for April 2018 to March 2019 was at 89%.

Each complaint received by the trust was reviewed and referred to the appropriate division to investigate with the support of a complaints officer as required. Each division identified the
appropriate lead and would investigate and prepare a response. Once complete, the response was returned to the complaints team to review for quality assurance purposes before being forwarded to the chief executive/chief nurse for approval.

The trust acknowledged that the quality of investigation and identifying learning by division could be improved. However, there was good example of where investigations had led to direct action and improvement, as well as example of a ‘weekly complaint bulletin’ provided by acute medicine that clearly outlined the complaint summary, the effect on the patient, the impact on staff and lessons learnt and immediate actions.

The director of nursing for patient experience and engagement chaired the monthly patient experience and engagement assurance group (PEEAG) and was responsible for ensuring the board had oversight of complaints. The PEEAG allowed nursing leads to come together and share learning. The trust said that they hoped this would bring a more uniform approach to investigation and shared learning, as positive examples where shared.

Learning was also disseminated to staff through daily huddles and we saw example of this during our core service inspections.

Between April 2018 and March 2019 there were 92 reactivated complaints, down on 134 from the previous 12 months. The main themes identified were disagreement with the trust’s response or that not all issues had been addressed.

A local resolution meeting was offered to all complainants, although this was not always accepted. The trust had introduced the option of video recording these so that the complainant could take away the recording and go over what was discussed in their own time. The trust gave example of how this had positively helped a family through their bereavement process.

Between April 2018 and March 2019, 22 complaints had been escalated to the Parliamentary Health Service Ombudsmen. Two were partially upheld and recommendations made to the trust accordingly.

On review, we found investigations were thorough and a detailed response was provided. We found that when actions were suggested, the accountable person was clearly assigned. The trust evidenced an open and honest approach to dealing with complaints. The trust explained that if the quality of the report returned by a division was not adequate, the assigned complaints officer would provide support.

Since our last inspection, the trust had further developed its approach to identifying learning from deaths. An associate medical director was the appointed lead for learning from mortality and was supported by three other consultants and dedicated administrative support that made up a ‘mortality faculty’. There was comprehensive quarterly reporting to board. The chief medical officer was the executive lead for mortality.

Each speciality at the trust had regular mortality and morbidity (M&M) meetings and a mortality assurance group met monthly to review deaths across specialities. There was improved multidisciplinary engagement among clinical and nursing staff and the end of life care team were working with community services to reduce unplanned and inappropriate admissions to hospital.

The mortality faculty was engaged with ensuring that all in-patient hospital deaths were reviewed and where any concerns about the circumstances of the patient death were raised, an in-depth structured judgement review (SJR) using the Royal College of Physicians approved methodology was conducted.
We reviewed 10 SJRs selected by the trust. All were fully completed and were subject to first and second review with evidence of good challenge around judgement statements. Judgements on care was candid and honest and there was good examples of learning, including example of working with the Coroner and round table discussion to establish need for further investigation.

The mortality faculty had identified some recurring themes. This included decision making and recording of ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) and higher than expected resuscitation rates. Recognising the cultural challenges associated with decision around resuscitation and end of life, the end of life care team were working to address this.

The process of completing a mortality review checklist at the time of medical certification of cause of death was now completed electronically. This had improved communication and sharing of information. The trust were also currently in the process of developing a medical examiner role to support learning from deaths.

The team produced a monthly newsletter that was clear, concise, easy to read and identified key learning points. An annual report was also produced of similar standard.

The trust had a research and innovation team, overseen by the chief medical officer and included identified clinical research staff. The trust had commenced a programme to improve research services offered to patients over the coming years. The trust was working with the North Thames Clinical Research Network, ensuring research carried out by the trust was by trained and experienced research staff. There were 1214 patients approved by the NHS Research Ethics Committee partaking in research involving the trust during 2018/19.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medical care (including older people’s care)</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>Provider wide</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Other</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>Medical care (including older people’s care)</td>
</tr>
<tr>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td>Other</td>
</tr>
<tr>
<td>Quality management systems (QMS) standards - BS EN ISO 9001:2015</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>British Society of Uro-gynaecology (BSUG)</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>British Society for Gynaecological Endoscopy (BSGE)</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>British Society for Colposcopy and Cervical Pathology (BSCCP)</td>
<td>Gynaecology</td>
</tr>
<tr>
<td>Baby Friendly Initiative (BFI) stage 2</td>
<td>Maternity</td>
</tr>
<tr>
<td>HFEA Licence</td>
<td>Gynaecology</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

The trust has two emergency departments at King George Hospital and Queen’s Hospital.

Both sites have a medical assessment unit, these are, however, under the governance of the medical care directorate. There is an urgent care service on the Queen’s Hospital site which is provided by an external, independent provider. However, all non-ambulance patients arriving at the hospital for urgent or emergency care are initially seen and assessed in the urgent care centre, by staff from the independent provider. If those staff determine that their condition is sufficiently serious, they will be referred on to the trust’s emergency department for further assessment and treatment.

Queen’s Hospital is a receiving hospital for trauma and paediatric emergencies by ambulance. The site has a major trauma centre for isolated head injuries and a hyper acute stoke unit. There is a dedicated ambulance receiving area to allow for the rapid assessment of ambulance patients.

(Source: Routine Provider Information Request (RPIR) Acute – Context tab)

Activity and patient throughput

Total number of urgent and emergency care attendances at Barking, Havering and Redbridge University Hospitals NHS Trust compared to all acute trusts in England, March 2018 to February 2019
From March 2018 to February 2019 there were 225,065 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2018/19 compared to 2017/18. In 2017/18, the proportion was higher than the England average and in 2018/19 the proportion was the same.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2018 to February 2019
Day one of our inspection coincided with the busiest day of the year for the trust with 629 patients in attendance. The trust receives, on average, 188 ambulance attendances per day.

Is the service safe?

Mandatory training

The trust set a target of 90% for completion of all mandatory training courses apart from information governance which has a target of 95%.

A breakdown of compliance for mandatory training courses at Queen’s Hospital urgent care department from April 2019 to June 2019 at trust level for medical staff in urgent care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>81</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>81</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>79</td>
</tr>
<tr>
<td>Fire safety</td>
<td>78</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>76</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>66</td>
</tr>
<tr>
<td>Sepsis (paediatric) e-learning</td>
<td>44</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>64</td>
</tr>
</tbody>
</table>
Conflict resolution initial training | 64 | 73 | 87.7% | 90.0% | No

Resuscitation level 2 - adult basic life support | 7 | 8 | 87.5% | 90.0% | No

Resuscitation level 2 - paediatric basic life support | 25 | 29 | 86.2% | 90.0% | No

Information governance | 65 | 83 | 78.3% | 95.0% | No

At trust level, urgent care met the target for six of the twelve mandatory training modules for which medical staff were eligible.

The trust did not report mandatory training completion rates for medical staff at site level. Medical staff work across both sites. The trust reported completion rates for medical staff only at trust level.

A breakdown of compliance for mandatory training courses at Queen’s Hospital urgent care department from April 2019 to June 2019 for qualified nursing staff in the urgent care department at Queen’s Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>132</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>132</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>132</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>127</td>
</tr>
<tr>
<td>Fire safety</td>
<td>127</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>127</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>126</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>123</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>44</td>
</tr>
<tr>
<td>Resuscitation level 3 - adult immediate life support</td>
<td>64</td>
</tr>
<tr>
<td>Sepsis (paediatric) e-learning</td>
<td>82</td>
</tr>
<tr>
<td>Resuscitation level 2 - paediatric basic life support</td>
<td>64</td>
</tr>
<tr>
<td>Information governance</td>
<td>111</td>
</tr>
</tbody>
</table>

Queen’s Hospital urgent care department met the target for eight of the 13 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses at Queen’s Hospital urgent care department from April to June 2019 for qualified nursing staff in urgent care that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>11</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>3</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>11</td>
</tr>
</tbody>
</table>
At trust wide, the urgent care department, met the target for eight of the 12 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Where the service had not met the target mandatory training rates for any staff groups they had missed this by very little and accounted for this as staff absence and the workload in the service. The senior leadership team informed us that there were additional training days planned for nursing staff working across both sites.

**Safeguarding**

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

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 at trust level for medical staff in urgent care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 4</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>69</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>23</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>47</td>
</tr>
</tbody>
</table>
Queen’s Hospital urgent care department met the target for three of the four safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

There were up to date policies for safeguarding adults and children, which were available to all staff via the intranet.

All staff understood their role in safeguarding patients and their families from harm. Staff were able to describe past safeguarding incidents and referrals they had made. They knew when and how to make a referral.

Staff were aware of issues including child sexual exploitation (CSE) and female genital mutilation (FGM), which formed part of their safeguarding training. They were aware of the government’s PREVENT strategy for recognising and interrupting radicalisation.

There was a safeguarding questionnaire to be completed by staff in all patient notes, to assess potential safeguarding risks. This had been completed in the records we checked.

In the paediatric urgent and emergency care service, staff routinely recorded the details of the adult accompanying the child. In addition, they recorded the child’s mother or father who were not present and asked questions about the child’s family life. Staff were aware of the “think family” initiative.

The service was part of the NHS Child Protection Information Sharing (CP-IS) network, which allowed the service to share and receive current and historic safeguarding concerns regarding patients with other NHS providers, the police and local authorities. The trust-wide named nurse for safeguarding children told us that whilst the system had been in use for several months, the service also sought email alerts from the local authorities in order to audit the effectiveness of the CP-IS system before relying on it entirely. They said that they were sufficiently satisfied with the system and would be relying on it going forward, without the need for email alerts. This demonstrated a commitment to ensuring that opportunities to safeguard patients were not missed.

There were two safeguarding nurse advisors within the service, working Monday to Friday. They offered learning, support and advice to staff around safeguarding issues. They were responsible for reviewing the records of all patients under the age of 18 seen in the service. This was to ensure that no potential safeguarding concerns had been missed and that any referrals that had been made had been processed appropriately. Where a safeguarding concern was retrospectively identified which had not been identified at the time, the safeguarding advisor would, in the first instance discuss the patient with the member of staff who saw them, in order to check whether a referral had been made and not documented or why they had decided not to make a referral. In addition, the safeguarding nurse advisor would also make the appropriate referrals at this stage. The safeguarding advisor told us that they also checked the records of any regular attendees, regardless of their age, on account of the specific vulnerabilities of this patient cohort.

The trust-wide named nurse for safeguarding children described the safeguarding knowledge of urgent and emergency care staff as very good. The trust-wide safeguarding team, with support from
the service-based safeguarding advisors provided information bulletins to staff in the service which were displayed in staff breakout areas. These were related to concerns arising from local incidents as well as national news stories.

Some staff expressed concerns about the volume of safeguarding referrals they had to make and the potential risk of missing a concern, given the volume and intensity of the workload.

Cleanliness, infection control and hygiene

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

All the areas we visited were clean, tidy and uncluttered.

There were up to date policies and protocols in place for infection prevention and control, which were accessible to staff via the intranet. This included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons and management of the spillage of body fluids.

We observed housekeeping staff undertaking routine cleaning rounds, which were appropriately documented as well as responding to requests for additional cleaning in response to spillages or following a patient being discharged from a bay.

Each bay had disposable curtains which were clearly dated indicated when they had been changed and when they were due for change. All curtains were in date.

The service made use of “I am clean stickers” to indicate when items of equipment had been cleaned.

Clinical waste management practices, including those for contaminated and hazardous waste, were safe and in line with national standards. There was a colour-coded system for disposal of waste, and clear segregation of clean and dirty equipment. The dirty utility rooms, used to store equipment to reduce the risk of infection and cross-contamination, were tidy and clean and kept locked.

The trust made use of re-usable sharps bins. These had tamper-proof lids which closed automatically when the bin had reached its fill level. All the bins were below their fill level. Sharps bins were available throughout the clinical areas. This was in line with health and safety regulation 2013 (The sharps regulations, 5 (1) (d)). The regulation requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.

There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected, and we observed staff using PPE appropriately. There were hand gel dispensers throughout the service with signs reminding visitors as well as staff to use them. Hand washing sinks were also available. We observed staff sanitising their hands following and before each patient contact.

All staff were bare below the elbow, in line with best practice. Staff told us they felt confident to challenge other staff who did not adhere to this.

Environment and equipment

The design, maintenance of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
All areas of the service were visibly clean and tidy. Corridors and fire exits were kept clear.

The service was divided into five areas based around a central reception desk, which was staffed at all times. These were the resuscitation area, for patients who had been admitted via ambulance requiring resuscitation or trauma care; RAFTing (rapid assessment & first treatment), where all other patients who attended via ambulance or who had been escalated from the urgent care centre were initially assessed; Majors A, for patients who were admitted with more acute conditions or injuries; Majors B, for patients who had been admitted with lower acuity; and a paediatric emergency department.

There was a helipad for trauma patients attending via air ambulance. This was located near to the entrance of the resuscitation area.

There were nine bays in the resuscitation area, including a trauma bay, one paediatric bay (which also had equipment for neo-natal patients) and a bay which could be used alternatively for adults or children. There was immediate access to the resuscitation area from the ambulance entrance, as well as two quiet rooms for family members.

The RAFTing area had eight chairs, for patients considered “fit to sit” as well as eight trolley bays and two assessment rooms. There was a central desk for medical staff in the area, meaning that all patients entering the service were seen immediately by a member of the medical team, in addition there was a nurses’ station opposite the medical desk, which allowed the nurse in charge a full view of the area.

Majors A had 24 bed bays based around a central nurses’ station. In addition, there was a psychiatric assessment room. This had been risk assessed to check for ligature points and lines of sight. The bay nearest to the nurses’ station, which had walls around it, as opposed to curtains was used for patients requiring isolation. In addition, it could be used when available for patients with dementia, learning disabilities or mental health patients requiring a bed.

Majors B had five cubicles and a seating area for patients deemed fit to sit, as well as a central nurse’ station. When we visited the area on day one of the inspection, it was extremely busy there was no specified number of patients that could be in the fit to sit area, with some seats being used alternately throughout the day by patients or family members. Patients and their relatives were sitting very close to each other in the crowded seating area. There were not clear lines of site between the nurses’ station and the desks used by medical staff and patients. In addition, staff were not assigned responsibility for particular chairs or bays, meaning there was a risk patients would not be routinely monitored. Whilst we were in the unit, patients frequently had to call out or ask a passing staff member of staff for assistance. Some patients were calling out on behalf of one another. We raised this issue with the local leadership. It was appropriately escalated to the senior leadership team and an action plan was immediately devised. When we visited the unit the following day, despite being equally busy, it was much calmer and more organised. The chairs had been moved around the walls, facing towards the nurses’ station, meaning there were clear lines of sight. Each of the chairs had been numbered and a rota drawn up with specific chairs assigned to specific members of staff. This significantly reduced the risk of a deteriorating patient not being recognised in a timely manner.

The paediatric emergency department was appropriately configured and equipped for children. It had eight trolley bays and two cubicles for patients requiring isolation or babies under three months, who were at increased risk of infection.

Staff told us that they had access to the relevant equipment when needed.

There were standard red resuscitation trolleys in each of the clinical areas. These were fully stocked. Nursing staff undertook a weekly stock check of the trolley. The trolley was kept sealed with a
numbered tag. The tag was checked daily and signed for. Additionally, there were resuscitation trolleys in each of the bays in the resuscitation area, with paediatric resuscitation trolleys in the paediatric resuscitation bay and in the bay which could be used for either adults or children.

Spare consumables and other equipment were appropriately stored and labelled. Consumables including fluids were in date.

Assessing and responding to patient risk

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

Patients presented to the department either via ambulance via an ambulance-only entrance or were brought into the unit by staff from the on-site emergency care centre, which was managed by a separate independent provider.

All adult patients were booked in at a central reception.

Patients brought from the emergency care centre were seen by a middle grade doctor in the RAFTing area for triage (triage is the process of determining the priority of patients’ treatments based on the severity of their condition).

Patients were therefore triaged within 15 minutes of arriving in the department, this did not include, however, the time they may have spent waiting in the urgent care centre, therefore creating a situation where patients may have a prolonged wait for appropriate treatment.

Ambulance patients were taken to the RAFTing area for handover and triage or straight into resuscitation if required. Where a patient required resuscitation, the ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment, so a team was waiting for them on arrival.

Paediatric patients were booked in at a separate reception and assessed by a middle grade doctor on arrival at the unit. Staff told us that there the paediatric unit was not always staffed by paediatric trained staff, including medical staff.

There was seven-day a week medical cover. This meant patients were seen by either a consultant or ST4 (a specialty doctor in training) on arrival in the department which ensure appropriate assessment.

The waiting area in Majors B, for patients awaiting transfer to one of the cubicles or the fit to sit area, was very crowded. Patients in the waiting area could be observed through a window by the Majors B receptionist but were not routinely monitored by clinical staff. During our inspection, we encountered an unwell patient in the waiting area, who’s condition was deteriorating. We alerted staff and the patient was cared for appropriately. Following this incident, senior staff introduced a policy for a member of clinical staff to physically visit the waiting area every ten minutes to carry out a visual assessment of patients. Staff signed a log to indicate this had taken place.

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
emergency department staff?

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The median time from arrival to initial assessment was similar to or higher than the England median for 10 out of the 12 months from June 2018 to May 2019. February and May 2019 were the only months in the 12-month period when trust performance was better than the England average.

From July 2018 to June 2019 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen’s Hospital.

The percentage of journeys with a turnaround time over 30 minutes, increased over the winter months from November 2018 to January 2019. In January, Queen’s Hospital reported the highest percentage of 81.3%. Percentages improved from February to May 2019. However, in June 2019 percentages increased once again to 80.7%.

Ambulance: Number of journeys with turnaround times over 30 minutes - Queen’s, Romford - A&E

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Queen’s, Romford - A&E

(Source: National Ambulance Information Group)
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2018 to March 2019 the trust reported 543 “black breaches”, with the highest monthly number (140) in January 2019.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

The service had the highest ambulance attendance rate in Greater London. In addition, the service was accessed by East of England Ambulance Service.

Staff described a positive working relationship with all ambulance staff. We observed positive co-operative interactions between ambulance crews and hospital staff.

Senior staff told us they had a positive working relationship with the London Ambulance Service’s leadership team. They had access to LAS call centre team, which allowed them to ask that all but the highest acuity patients be re-directed in the case of over-crowding in the service. Staff told us, however, that when this occurred, ambulances from the EEAS still attended. They said that as ambulances primarily attended from LAS, a formal relationship had not been established with EEAS.

The department was a Trauma Centre. There was a trauma team activation procedure which provided clear guidance for staff in the event of adult or paediatric patients trauma. This ensured timely activation of suitably skilled trauma team members. It also allowed the activation of specific protocols for severe haemorrhage and brain injury. Trauma team members were available within 10 minutes of a trauma call.

In the event of a trauma, the department received an alert to notify the staff of the patient’s imminent arrival. All relevant information was documented for the trauma team including injury, physiological and anatomic criteria.

Stroke patients arriving by ambulance were screened using the Face Arm Speech Test (FAST) screening tool by the ambulance crew. If patients screened positive for FAST the resuscitation department was informed via a call and the patient transported to the department. Upon arrival in the department all stroke patients were transferred to resus for further assessment.
There were sepsis risk assessment tools and a sepsis action plan pre-printed in all patient notes. Staff we spoke with were aware of the sepsis action plan. There was a trust-wide sepsis steering group which met monthly to discuss instances of sepsis and serious infection and shared learning and best practice. There was a sepsis/deteriorating patient nurse within the department, who supported staff to provide timely effective care to septic or deteriorating patients. The trust had received praised from NHS England for its sepsis management programme.

The department used the National Early Warning Scoring System (NEWS), and the modified versions for children. In the patient notes we checked the NEWS scores had been appropriately completed, document and calculated.

There was 24-hour access to support from the local mental health trust. Staff said that usually assistance from the mental health trust was prompt and that they had a very good working relationship with them. At busy times, however, there could be delays in mental health staff attending the unit, at which times, telephone advice was offered.

There were established arrangements for obtaining mental health assessments for patients under the age of 16.

Appropriate arrangements were in place to ensure that children and young people who harm themselves were seen and assessed by Child and Adolescent Mental Health Services (CAMHS) professionals. Children and young people were seen in the department for their presenting medical condition were assessed by a CAMHS clinician.

**Nurse staffing**

The service generally had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction. However, there was a shortage of paediatric trained staff, meaning that the paediatric unit was not always staffed by specialist nurses, AHPs and doctors.

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at Queen’s Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>493.8</td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td>24,691.5 (4.2%)</td>
<td>57,324.3 (9.6%)</td>
<td>13,743.0 (2.3%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>208.7</td>
<td>28.8%</td>
<td>21.7%</td>
<td>19.3%</td>
<td>22,730.4 (3.9%)</td>
<td>55,192.4 (10%)</td>
<td>13,234.1 (2.3%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)
Nurse staffing rates within urgent and emergency care Queen's Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were found in monthly rates for vacancy and turnover. There was not enough variation in vacancy and turnover rates over the last 12 months to comment on the performance for these metrics.

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed an upward trend from November 2018 to March 2019. This could be an early indicator of deterioration. We were told that the trust had taken action in response to high sickness rates. However, they did not indicate how sickness rates had improved. 

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change.

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from May 2018 to November 2018. This could be an early indicator of improvement.
The trust only reported agency and bank usage rates for nursing staff working across both sites. The table below shows the agency and bank use for nursing staff working across both sites in urgent and emergency care.

### Urgent and emergency care annual staffing metrics

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>N/A</td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4,222.3 (3.6%)</td>
<td>5,421.3 (4.6%)</td>
<td>7,658 (6.5%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change.
Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Nursing Bank Agency tabs)

Senior staff told us that they were responding to the increased need to use agency staff by trying to fill vacant shifts with bank staff in the first instance, in order to ensure consistency of care and training opportunities. Where agency staff were used, they had a full induction. The service used the same agency staff wherever possible to improve consistency.

At the time of our inspection, ten new permanent nursing staff were undergoing induction into the service to reduce the reliance on bank and agency staff. In addition, the service had been part of an overseas recruitment drive to recruit nursing staff from the Philippines, who were due to start at the trust shortly after our inspection.

**Medical staffing**

The table below shows a summary of the medical staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable. As medical staff worked across both sites, the trust did not report staffing metrics for medical staff at site level. Medical staff work across both sites.
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>576.5</td>
<td>29.7%</td>
<td>17.0%</td>
<td>18.6%</td>
<td>45,090.2 ()</td>
<td>63,154.0 ()</td>
<td>11,529 ()</td>
</tr>
<tr>
<td>Medical staff</td>
<td>154.1</td>
<td>48.9%</td>
<td>17.3%</td>
<td>11.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust did not supply the total available hours for medical staff. We could therefore not calculate rates for bank, agency, and hours unfilled. We queried this with the trust and did not receive a response.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and sickness rates.

Monthly turnover rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

The medical leadership told us medical staffing within the unit had stabilised since our last inspection. They attributed this in part to improved training opportunities for junior and middle grade doctors.

In April 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 45 whole time equivalent staff working in urgent and emergency care at Barking, Havering, and Redbridge University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>30%</td>
</tr>
</tbody>
</table>
The medical leadership had made significant efforts to improve the skill mix for medical staffing, which had taken effect by the time of our inspection.

At the time of our inspection, the service had 24-hour consultant presence in each of the units, this was better than the national standard of 16 hours.

The medical leadership had sought to address the shortage in middle career doctors by introducing Advanced Nurse Practitioner (ANP) and Advanced Clinical Practitioner (ACP) roles. Advanced Nurse Practitioners are Registered Nurses who have done extra training and academic qualifications to be able to examine, assess, make diagnoses, treat, prescribe and make referrals for patients who present with undiagnosed/undifferentiated problems. ACPs are Allied Health Professionals (AHP)s who undertake similar training.

The department’s ANP and ACP programmes had received national recognition and accreditation through a local university.

At the time of our inspection, there were four ANPs and one ACP working in the service. In addition, there were staff undergoing training on a course provided jointly between the trust and a local university. Nurses and AHPs on the course received the same consultant training input as junior doctors. Staff said the introduction of the ANP and ACP roles had a significant impact on mitigating against the shortage of middle career doctors, who would ordinarily deal with patients presenting with undiagnosed/undifferentiated problems.

We spoke with an ANP who said their training had been “excellent” and described a positive, ongoing, supportive relationship with the consultant body. Staff undertaking ANP or ACP training were given protected time for research and training. In addition, they received leadership training.

**Records**

Staff told us that they sometimes had difficulty in accessing up-to-date, accurate and comprehensive information on patients’ care and treatment.

The service used both electronic and paper-based records. Records were securely stored, and computer screens were left locked when unattended.
We reviewed 10 patient records. These were clearly and accurately completed. Risk assessments such as falls risks were documented in the records. Each patient record pack included a sepsis risk assessment flow chart and a copy of the service’s standardised sepsis pathway.

Staff told us records were readily available when needed. Records were shared, where appropriate, with the community services and the local mental health trust.

**Medicines**

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

Medicines were stored securely and within locked cabinets. Controlled drugs (CD)s were kept in locked cabinets within a locked cabinet, with the nurse in charge holding the keys. We saw CDs had daily checks and were dispensed by two nurses as per trust guidance.

All medicines we checked were within date.

Medicine fridge temperatures were checked and recorded daily. Fridge temperatures were within the specified ranges, ensuring they were safe to use. There was a standard operating procedure for moving medicines in the event of the fridge breaking.

Oxygen cylinders were stored securely and safely in racks. All cylinders were in date.

We found that all the patient group directions (PGDs) utilised in the service were in date and to the correct standard. A PGD is a legal framework that allows the supply or administration of a specified medicine by named, authorised health professionals to a group of patients for pain relief or treatment of a condition described in the PGD without the need of a prescription.

**Incidents**

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

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2018 to May 2019, the trust reported three never events for urgent and emergency care.

Queen’s Hospital reported two incidents. The first incident reported in June 2018, involved sub-optimal care of a deteriorating patient, and happened when staff unintentionally connected an air flowmeter to a patient needing oxygen.

Queen’s Hospital reported a second incident, a surgical or invasive procedure incident meeting SI criteria, in December 2018. The incident involved a retained foreign object post procedure and happened when staff did not remove a guide wire from a naso-gastric feeding tube.

(Source: Strategic Executive Information System (STEIS))
It was concerning that the second incident occurred at Queen’s Hospital was like an earlier incident at the King George’s site, in May 2018, relating to a needle guide being left in a cannula. There were similar incidents in other core services within the trust, suggesting that the sharing of learning between sites and departments is not as effective as it could be.

Queen’s Hospital reported 23 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2018 to May 2019. A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>7</td>
<td>30.4%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>6</td>
<td>26.1%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>3</td>
<td>13.0%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

We had sight of the root cause analysis investigations for two serious incidents which occurred within the service. These were thoroughly and appropriately investigated. Learning was identified in each of the cases and actions plans put in place to mitigate against the risk of the incident reoccurring. We were told that all root cause analysis documents were shared with all medical and Band 7 nursing staff with the intention that the Band 7 nurses would cascade to their staff at handovers and ward meetings.

Staff we spoke with could talk about learning from incidents within the service, and changes that had been made a direct result. However, the repetition of the incidents involving a guide wire across both the King George’s and Queen’s site, as well as it’s occurrence in other core services suggested that learning from other areas within the trust may not be being shared or sufficiently emphasised at the meetings.

Staff told us they felt confident to report incidents and near misses and used an electronic reporting system to do so. They told us they always received feedback on incidents they reported or where involved in. Once reported through the electronic system, incidents were screened by lead nurse or clinical leads and referred to a relevant senior member of staff for investigation. Serious incidents were escalated to the trust’s governance team for review and the allocation of an independent investigator.

The clinical governance team shared a monthly “lessons learned” newsletter, setting out the learning from all incidents in the previous month.

Senior staff told us they encouraged staff to report incidents. They said incidents were treated as learning opportunities. This was confirmed by staff. In addition, we saw an example of an incident which occurred during our inspection, where the relevant member of staff was offered additional training and support.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, no falls with harm and four new urinary tract infections in patients with a catheter from May 2018 to May 2019 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Barking, Havering and Redbridge University Hospitals NHS Trust

1. Total pressure ulcers (4)

2. Total CUTIs (4)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

The safety thermometer was clearly displayed in each of the clinical areas.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
There were clear policies and procedures available for staff to follow via the intranet. Staff were able to show us how they accessed policies. All of the policies we looked at were up to date and had been appropriately reviewed. Policies were based on relevant guidance, for example from the National Institute for Healthcare Excellence (NICE) and the College of Emergency Medicine.

The department carried out regular audits, including national audits requested by the Royal College of Emergency Medicine (RCEM) and audits to support and monitor implementation of NICE guidance. The service had a clinical audit programme in place for 2019-20 which included care of children in emergency departments, major trauma audit (Trauma Audit Research Network - TARN), mental health - care in emergency departments and assessing for cognitive impairment in older people. At this inspection we found that all audits were on track and regularly reviewed.

The service used sepsis toolkit for emergency medicine that was developed jointly by the RCEM and the UK Sepsis Trust. The RCEM recommends a minimum of 80% of permanent staff should receive appropriate sepsis training which should be audited at least biannually. The service set the target higher at 95% and audited the compliance with the toolkit each month. If a staff member was not compliant they offered them additional training.

Medical staff carried out a number of local clinical audits to assess and improve effectiveness of care provided. For example, in the last twelve months staff carried out an audit of patients presenting with suspected community acquired pneumonia (CAP) or contamination rate of peripheral blood cultures. Staff undertook audits based on NICE and other guidelines such as management of urinary tract infection in females or antibiotic prescribing to check their compliance with the antimicrobial prescribing guideline. Staff also carried out regular audits to assess compliance with the local policies and operational and clinical practices for example falls, discharge, skin integrity checklist or handwashing audits. Each day of the week staff collated data for a different audit. Following an audit staff completed ‘corrective action plan for audit finding’ document which outlined summary of findings, corrective action to be taken, method of sharing information with staff and the date of the next audit.

The service was undertaking research in the use of artificial intelligence within urgent and emergency medicine. There was also a research team within the service.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

In the CQC Emergency Department Survey, the trust scored 6.8 for the question “Were you able to get suitable food or drinks when you were in the emergency department?”. This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Cold drinks were available to patients in waiting areas. In both Majors A and Majors B there was a choice of cold drinks and water available, as well as biscuits for patients. In addition, housekeeping staff undertook regular rounds offering patients tea and coffee.

For patients remaining on the unit for longer periods there was a menu for hot and cold food available. There were menus to cater for a range of dietary requirements, including halal, kosher and vegetarian.
Pain relief

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

In the CQC Emergency Department Survey, the trust scored 4.2 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was worse than other trusts.

The trust scored 6.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse than other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>4.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>6.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Throughout our inspection we generally observed staff providing appropriate pain relief to patients when requested in a timely manner. In addition, staff proactively assessed patients’ pain using a pain scoring system. This was recorded in patient notes. There were alternative pain scoring systems for patients with difficulty communicating. However, on day one of our inspection, we observed patients in Majors B having to make repeated requests for pain relief and attention from staff. This appeared to be due to the cluttered nature of the seating area and the fact that staff were not assigned to individual seat numbers. This was addressed during our inspection.

Patient outcomes

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

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Queen’s Hospital emergency department did not meet all the national standards.

The department was in the upper UK quartile for three standards:

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 96.4%; UK: 77%.

• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 40.0%; UK: 19%.

- Standard 5b (fundamental): within 4 hours (moderate). This department: 46.7%; UK: 28%.

The department was in the lower UK quartile for two standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 9.9%; UK: 25%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  This department: 25.4%; UK: 52%.

The department's results for the remaining two standards were all within the middle 50% of results.

Following on from this audit, the service had introduced two specialist asthma nurses.

In the 2016/17 Consultant sign-off audit, Queen's Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for none of the standards.

The department was in the lower UK quartile for one standard:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.

The department's results for the remaining two standards for which the site provided data were all within the middle 50% of results.

In the 2016/17 Severe sepsis and septic shock audit, Queen’s Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 93.6%; UK: 69.1%.

The department was in the lower UK quartile for four standards:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement
of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 44.9%; UK: 64.6%.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 30.8%; UK: 60.0%.

• Standard 5: Blood cultures obtained within one hour of arrival. This department: 5.1%; UK: 44.9%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 1.3%; UK: 18.4%.

The department’s results for the remaining three standards were all within the middle 50% of results. The clinical leads told us that in response to this audit, the service had made significant improvements in sepsis care, training and knowledge. They said sepsis now formed part of the induction for all staff. The service held monthly sepsis audits to ensure staff knowledge of sepsis. This was more frequently than the UK Sepsis Trust’s recommended 6 monthly knowledge audits.

In addition, the completion of sepsis assessments in patient notes was audited every two weeks and feedback was provided to the relevant staff immediately via email. Where staff had made errors in the completion of the assessments, they would be offered support and training to ensure understanding. Key messages from audits were shared at handovers. The result of the sepsis assessment audits was presented at monthly quality safety meetings as a standing item on the agenda.

The table below summarises Queen’s Hospital’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment</strong> (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td>88.5 - 100+%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</strong> (Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</td>
<td>69 mins</td>
<td>Takes longer than TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</strong> (Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent</strong></td>
<td>0.0%</td>
<td>Lower than TARN aggregate</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
and emergency care (Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)

<table>
<thead>
<tr>
<th>Risk-adjusted in-hospital survival rate following injury</th>
<th>1.8 additional survivors</th>
<th>As expected</th>
<th>Met</th>
</tr>
</thead>
</table>

(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)

(Source: TARN)

From June 2018 to May 2019, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

The average unplanned re-attendance rate at the trust was 10.4% compared to an England average of 8.1%.

Unplanned re-attendance rate within seven days - Barking, Havering and Redbridge University Hospitals NHS Trust

(Source: NHS Digital – A&E quality indicators)

Competent staff

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

From April 2018 to March 2019, 76.7% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 90.0%. For the period April to June 2019, 29.9% of staff had received an appraisal:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who</td>
<td>Eligible</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
The majority of staff we spoke with told us that they had received their appraisal in the last six months. They told us that their appraisals were meaningful, and that their managers were supportive in encouraging them to undertake additional learning and set new targets.

Staff were experienced, qualified and generally had the right skills and knowledge to meet the needs of patients. Practice development nurses (PDNs) supported the learning and development needs of staff within the emergency department by auditing their practice and identifying training needs. Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff received any specialist training for their role. All new staff had a full induction tailored to their role before they started work. New nursing staff attended a three-day comprehensive induction which included corporate welcome, orientation around the department and focused on knowledge, skills and practice. The knowledge, skills and practice programme included essential training, neurological observations, electrocardiogram (ECG), manual blood pressure competences, simulation of patient assessment, minor injuries, slings, knee braces, burns dressing amongst others.

Medical staff were complementary about the induction they had which they found to be comprehensive and not rushed.

Agency staff also underwent induction and orientation prior to starting their shift. We observed induction of an agency nurse and they seemed well supported. The service kept copies of the
agency nursing staff competencies but also did their own assessment to ensure they were competent for the allocated area. Senior staff told us any CV of an agency staff had to be approved by the clinical lead before they were allowed to work.

The PDN delivered triage training which comprised of one day training followed by 20 patients observed competency assessment. Triage staff started as ambulance assessors; to gain their competences they needed to assess at least ten major and ten minor patients.

Emergency nurse practitioners (ENPs) attended medical study days and addressed any additional learning needs with a consultant during feedback sessions.

Staff attended structured ‘keep in touch’ (KIT) training days four times a year and this included training on mental health, incidents, complaints, safeguarding, changes to practice, as well as specific topics such as dementia, domestic violence or knife crime.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Nurses followed the Royal College of Nursing curriculum and competency framework for emergency nursing to develop their competences in, for example, resuscitation, paediatrics, or mental health. When a staff member was allocated to a new area such as resuscitation they initially shadowed their colleagues until they were familiar and confident with their role and responsibilities.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Several nurses we spoke with told us they completed a university course founded by the trust. Unfortunately, due to funding only one out of six nurses that expressed interest secured a place on a recognition and management of the acutely ill child course. Staff told us that funding was an issue and some nurses paid for their own training courses and attended these in their own time. Senior staff tried to overcome the founding issues by offering alternative training opportunities.

The paediatric ED was not always fully staffed by paediatric qualified nursing staff. The department sought to mitigate this by ensuring there was always at least one paediatric nurse on shift. However, there was a risk that when this nurse was busy, or occupied with another patient, paediatric patients would not be being treated by a nurse with the full relevant skill set.

In order to further mitigate this, the service upskilled their adult ED nurses in paediatric emergency care through different initiatives. For example, they invited nurses to a weekly teaching session. The session was delivered by an ED paediatric consultant and focused on different aspects of care and treatment, for example diabetic child, bronchiolitis or resuscitation. Also, every adult ED nurse attended at least one paediatric 'keep in touch' (KIT) training day per year.

The PDN created a development pathway for nursing staff in line with the RCN competencies. The pathway clearly showed how nursing staff could progress in their role and what skills and knowledge were required.

Nurse were given opportunity to rotate between different departments within the hospital to gain skills and further their knowledge. For example, some staff worked on the children’s ward.

Senior ED doctors could pursue special interests, for example in endocrinology or ultrasound. Also, junior doctors rotated to different areas of the hospital, such as paediatric department, anaesthetic department or ITU to gain new skills and experience which positively contributed to patient care in ED. General ED doctors had additional teaching sessions in paediatrics such as asthma or sepsis. They also could attend a weekly paediatric simulation session where real case scenarios were presented.
The service was in the process of developing A&E academy for middle grade doctors who considered applying for a Certificate of Eligibility for Specialist Registration (CESR). The CESR is a route to entry on to the specialist register for those doctors who have not followed an approved training programme but have knowledge, skills and experience equivalent to the approved curriculum for their specialty.

As well as completing mandatory training, security staff completed training in managing violent patients and advanced restraint techniques. Medical and nursing staff were complementary about security staff and said they were “very good and helpful” when dealing with challenging behaviours.

While the service had an extensive and comprehensive teaching programme staff said it was difficult to forward plan teaching activities due to limited space and suitability of rooms that were available. As a consequence, clinical staff could not book some courses ahead of time as these appeared unavailable.

Managers made sure staff attended team meetings or had access to meeting minutes when they could not attend. Staff room had a ‘quick learning points’ notice board with a number of topics and key points to educate staff in some common areas such as asthma in children and adults. Senior staff identified poor staff performance promptly and supported staff to improve. Managers supported staff to develop through yearly, constructive appraisals of their work.

Several consultants, middle grade and junior doctors expressed concern about the risk of de-skilling in the department in relation to the lack of minor injuries work undertaken. They said that because minor injuries were dealt with in the urgent care centre, which was provided by an independent provider, they were not afforded regularly opportunities to undertake minor injuries work. As a result, they expressed concern that they would lose the competency to do so. Senior staff told us that they recognised this issue. Efforts had been made to mitigate the problem for junior doctors, as minor injuries work was a required part of their education. Therefore, the trust had established a service level agreement with the independent provider whereby the junior doctors could rotate through the urgent care centre. This was not available, however, to consultants or middle grade doctors.

Medical staff also told us that the lack of minor injuries work had the potential to impact on their morale and the morale of all staff, including nurses and allied health professionals within the unit as it meant that they were only dealing with patients at the higher end of acuity on a day to day basis, meaning significantly increased pressure on them and the risk of burnout.

**Multidisciplinary working**

*Within the department, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

We observed effective multidisciplinary working locally within the service. Allied health professionals (AHPs), doctors and nurses said that their professional opinions were sought and listened to.

However, staff at all levels expressed concern regarding the lack of in-reach by other specialties within the hospital into the service. They told us that staff from the majority of specialties were not proactive in visiting the service to assess patients, begin their care plan and begin the process of admitting them. In addition, they said that the majority of patients were not seen by the relevant specialty for their condition within 30 minutes of the decision to admit them, in breach of best practice guidelines. This meant that patients had a prolonged wait for access to the right treatment, as well as increasing the pressure on the service and, consequently, delays for patients waiting to be seen. They said that when they did contact the specialties to ask them to come and assess a patient,
it was usually not a clinician sufficiently experienced or qualified to make a decision regarding the patient’s care, meaning further delays.

The clinical leads within the service told us that they had escalated this concern to the overall trust leadership as well as with the leadership of the various specialties but that there had been no improvement so far.

They said that the exceptions were the geriatric medicine and nutritionist teams, whom they described as proactive in visiting the unit, assessing and treating patients there and admitting them to their own services.

Seven-day services

**Key services were available seven days a week to support timely patient care.**

The department provided care to adults and children 24 hours a day, 365 days a year.

The service had 24-hour consultant presence on the unit seven days a week, this was above and beyond the national standard of 16 hours.

The department had access to a pharmacist 24-hours a day seven days a week.

There was dedicated access to two computerised tomography (CT) scanners and X-ray facilities 24 hours a day.

Blood products were available within the resuscitation room which meant there was direct access 24 hours a day for patients who required intervention.

There were AHPs from the Home First team, who worked with colleagues in the community to facilitate patients’ returning home following assessment and treatment in the department based in the unit 08:30 - 16:00 every day. This had been identified as the time when those patients requiring their services would be likely to attend.

Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

We observed physiotherapists advising a patient awaiting discharge about the importance of regular exercise and movement and making suggestions for simple exercise that could be done at home.

There was a range of leaflets available with advice around reducing alcohol consumption and stopping smoking. Where relevant, staff signposted patients to these and related services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>188</td>
<td>195</td>
<td>96.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care qualified nursing staff met the target for completion of MCA/DoLS training.

A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>66</td>
<td>74</td>
<td>89.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the target for completion of MCA/DoLS training.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training for staff at Queen’s Hospital.

A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at Queen’s Hospital for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>129</td>
<td>136</td>
<td>94.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in urgent and emergency care at Queen’s Hospital met the target for completion of MCA/DoLS training.

A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>66</td>
<td>73</td>
<td>90.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met by medical staff.
All staff we spoke with had a clear understanding of the Mental Capacity Act (MCA) and deprivation of liberty safeguards. We saw mental capacity assessments clearly documented in patient notes.

Is the service caring?

Compassionate care

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

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Barking, Havering and Redbridge University Hospitals NHS trust from May 2017 to April 2019 are shown below.

Havering and Redbridge University Hospitals NHS trust – response rate May 2017 to April 2019

The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 56.3% and 91.2% from May 2017 to April 2019.

The data showed six points outside of the control limits and 12 unusually high/low data points. Additionally, for most of the period, the data showed that trust performance was potentially too stable and may be subject to too much control.
We observed positive, caring, interactions between staff and patients. In particular, we observed staff speaking with a regular attendee with kindness and compassion and remembering things that were important to that patient.

The porters spoke with patients who were awaiting medical attention and took the time to ensure they were comfortable.

All the staff we spoke with told us that patient care was their utmost priority. They expressed a genuine concern for patient welfare in their conversations with us and each other and sought to provide the best possible care to patients.

**Emotional support**

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

There was a board in the waiting areas entitled “It’s good to talk”, which encouraged patients and their relatives to talk about and share their experiences of care. The board included signposting to the chaplaincy.

There was a trust-wide chaplaincy team. Staff told us that they had a good relationship with the chaplaincy team, who were always available to visit patients in the unit. The chaplaincy team was multi-faith and had contacts in the community whereby it could call a chaplain from any faiths that were not represented on the team.

**Understanding and involvement of patients and those close to them**

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
The trust scored better than other trusts for none of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for 12 questions and about the same as other trusts for the remaining 12 questions.

Some of the themes included in the questions where performance was worse than other trusts were confidence and trust in staff, talking to each other as if patients were not there, contradictions in information given, not involving patients in decisions and poor communication in terms of medical side effects and guidance on when to resume normal activities. All questions are in the table below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>4.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall...</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Despite average to generally unfavourable Emergency Department Survey results, we observed medical, nursing and AHP staff taking the time to explain to patients what they were doing and why they were doing it. Staff provided patients with clear descriptions of their treatment options and the patient journeys available to them.

There were information leaflets available to patients about common conditions, treatments and medicines. These were available to staff to print online in different languages and there were also simplified English versions.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, senior staff highlighted issues in the wider healthcare system which impacted on the ability of the service to provide effective care. In particular, in terms of the number of patients attending the unit.

The department provided 24 hour a day accident and emergency services for children and adults in the local boroughs of Barking and Dagenham, Havering and Redbridge. In addition, they provided services for patients who suffered stroke or major trauma across neighbouring London boroughs and counties outside London.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and those living with dementia. The service had systems to help care for patients in need of additional support or specialist intervention.

There was a local homeless population who accessed the service. The safeguarding nurse advisor told us that staff had access to information leaflets from local charities which they could share with these patients. The safeguarding team had links to local charities and homeless shelters to whom they could directly refer these patients where appropriate.

There were regular meetings to discuss frequent attenders. These meetings were attended by the safeguarding nurse advisor to identify any potential safeguarding issues. The safeguarding nurse advisor also reviewed the notes for any frequent attenders following their visit to the department. The meetings also allowed for the development of specific care plans which reflected the needs of frequent attenders which were then made available in the patient’s records to be accessed by staff at their next attendance. In addition, frequent staff contacted local mental health, community and
primary care providers to ensure that there were appropriate care plans in place on a day to day basis for frequent attenders, to reduce future attendances at the department.

Generally, we found there was adequate space and seating in the departments waiting areas.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The observational ward offered a single sex facility for patients awaiting test results, requiring overnight observation or needing social services support for discharge.

The service could produce leaflets in languages spoken by the patients and local community. Patient information leaflets were not on display in languages other than English, but there was a facility to translate these into 137 languages. Staff told us telephone translation services were always available and face to face translation could be arranged. Staff, patients, relatives and carers could get help from interpreters or signers when needed, and we saw language line being used although we also saw an example where a family member was used for translation.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The service had a pantry with basic refreshments for patients such as tea, coffee, juice, yogurt, toasts, porridge or breakfast cereals. A hostess attended long staying patients between 7am and 7pm every three to four hours. Patients were offered sandwiches however if they were staying long they were offered a hot meal. If a patient had any additional dietary requirements, such as vegan or gluten free, food was ordered from the hospital canteen. Paediatric ED had a bottle warmer so that parents and carers could warm milk for their children. If required, they offered one of the treatment rooms to breastfeeding mothers.

The service relieved pressure on other departments when they could treat patients in a day. The frail older persons advice and liaison service (FOPAL) provided comprehensive geriatric assessment for frail elderly people and sought to enable people to return home with support where possible. The hospital had a frailty pathway to avoid unnecessary admission for elderly patients. The service organised a high intensity user's forum which was a multi-agency, multi-disciplinary meeting to discuss needs of frequent attenders and redirect them to more suitable services.

In response to the number of incidents of violence and aggression within the unit, there was a 24-hour security presence. The hospital's head of security had undertaken a number of night shifts in the service in order to understand the severity of the issue and had worked to develop a specific security plan for the department. The security team liaised with local police officers in order to ensure a prompt response to concerns.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

There were clinical nurse specialists in asthma, diabetes and dementia in the service who provided support and training to staff in providing care to patients with those conditions. During our inspection, we spoke with an oncology nurse who was engaged in in-reach within the department, visiting and assessing patients attending who had an existing cancer diagnosis. However, several consultants told us that further in-reach was needed from the oncology team. They said that there were occasions when chemotherapy patients, who are at increased risk of infection, were sitting in the department’s waiting areas, awaiting a bed in the oncology department. They said that these patients should have a passport, which allowed them direct admittance to oncology services.
told us they had raised this with the trust leadership and with the oncology team, but that this had not led to improvement.

Staff described the clinical nurse specialists as very supportive and knowledgeable. They said they felt confident that patients requiring input in those specialisms were being seen and treated by staff with the right expertise and experience.

There was a Home First team in the RAFTing areas, who assessed patients for discharge, and commenced discharge arrangements even before they had been admitted to the unit, in order to ensure that appropriate arrangements were in place for them to return home as soon as possible, in the best interests of the patient.

There was a frail older person’s advice and liaison service based in the department, who provided support and training to staff in caring for frail elderly patients as well as carrying out risk assessments and liaising with community health providers on behalf of patients.

There was a quiet bay in Majors A which was used for patients with dementia. Nursing staff had received training in the care of patients with dementia and said they could ask for support from the dementia link nurses when needed. Patients with dementia were identified by a sticker on their notes. Further, this was recorded on the electronic patient record, in the event of the patient attending again in future. Nursing staff completed a mental capacity assessment on all patients over 65 years old.

There was a named consultant and nursing lead for mental health in the department. Staff had received additional training in the care of patients with mental health concerns. At the time of our inspection, the service was introducing two policies specifically related to the care of mental health patients; an anti-ligature policy and a mental health patient experience strategy. Neither of these were operational at the time of our inspection.

During our inspection, there was a mental health nurse from the local mental health trust visiting a patient in the service who was awaiting transfer to a mental health bed, to ensure the right package of care could be prepared for them in advance. The mental health nurse described a positive working relationship with the nurses in the trust.

The LGBT network had placed a display board in the main corridor in the department which included information on the challenges sometimes faced by LGBT+ patients in accessing healthcare, to encourage staff to think about those challenges and provide appropriate support to patients.

The trust scored worse than other trusts for two of the three Emergency Department Survey questions relevant to the responsive domain. The trust scored about the same as other trusts for the remaining question.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.6</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Staff attributed the lack of privacy to the number of patients attending the unit each day. They said, however, patients’ privacy and dignity was their priority. We observed staff using curtains to ensure
patients’ privacy when carrying out assessments. However, the physical environment of the service and the number of patients meant that it was not always possible to ensure conversations could not be overheard.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The department was one of the busiest in London. With an approximately 500 patients attending per day. Collectively, King George’s and Queen’s Hospital urgent and emergency care departments saw 188 ambulance attendees per day. There was an average of 32 patients admitted to the resuscitation area per day.

Patients attending the ED independently were initially assessed by a clinician from the co-located urgent care centre (UCC), which was not part of the trust. The streaming clinician assessed patient’s condition and if necessary took some observations. Depending on patient’s presentation, the clinician streamed (directed) patients to the GP at the UCC, to the paediatric ED (for children under 16 years old) or to the adult ED.

Any child or adult considered by the streaming clinician to be very unwell was referred direct to paediatric ED or majors with registration being done later. This meant the sickest patients went through the system without delay. Remaining patients who required ED treatment waited for assessment by a triage nurse. Staff told us that if the waiting area became increasingly busy with many patients waiting to be triaged, they would deploy another triage nurse to improve the patients flow and reduce waiting times.

Patients arriving by an ambulance were triaged once they had been registered onto the hospital patient electronic system. Triaging staff could not enter patient’s details onto the system before the registration was completed. This meant there was around five minutes delay from the time a patient arrived and was being registered to being triaged. We saw that some staff commenced triage and noted any details on a piece of paper whilst registration was underway. This way they avoided unnecessary delays, however this was not the case most of the time. The service worked with the ambulance service and clinical commissioning group (CCG) to improve ambulance handover times.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in any of the months over the 12-month period from June 2018 to May 2019 and was also worse than the England average throughout the period.

Median times from arrival to treatment at the trust ranged from 77 to 115 minutes compared to the England median times of 56 to 66 minutes. The trust reported the longest median times in the winter months of January (115 minutes) and February 2019 (112 minutes).

**Median time from arrival to treatment from June 2018 to May 2019 at Barking, Havering, and Redbridge University Hospitals NHS Trust**
The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From July 2018 to June 2019 the trust did not meet the standard and performed worse than the England average.

Except for January and February 2019, trust performance against this metric followed a stable trend.

The average percentage of patients admitted, transferred, or discharged within four hours at this trust was 80% compared to the England average of 87%.

The clinical leadership told us that admitting, transferring or discharging 80% of patients within four hours was very good, in the circumstances faced by the service. In particular, the number of patients attending the unit on a daily basis.

The clinical leadership told us delays to admission, transfer or discharge often arose from poor flow within the other specialties within the hospital as well as a lack of available care in the community for patients to be discharged to. They told us other specialties within the hospital were reluctant to engage with the service and saw it as a “holding area” for patients. They said that they had raised this as a concern frequently with the trust-wide leadership and that, whilst there were pockets of good practice, for example in the dieticians’ and geriatric medicine teams, there had been little improvement in the working relationship with other specialties. In addition, they told us that they had raised concerns about the lack of appropriate community care with local commissioners and were working with them to identify key areas of need.

Four-hour target performance - Barking, Havering, and Redbridge University Hospitals NHS Trust
From July 2018 to June 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.

From July 2018 to June 2019 performance against this metric followed a stable.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Barking, Havering, and Redbridge University Hospitals NHS Trust

(Source: NHS England - A&E SitReps).

Over the 12 months from July 2018 to June 2019, 54 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in April (13) and June 2019.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>73</td>
<td>0</td>
</tr>
<tr>
<td>Aug-18</td>
<td>79</td>
<td>0</td>
</tr>
<tr>
<td>Sep-18</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Oct-18</td>
<td>70</td>
<td>1</td>
</tr>
<tr>
<td>Nov-18</td>
<td>82</td>
<td>0</td>
</tr>
</tbody>
</table>
Dec-18  |  108  |  0  
Jan-19  |  136  |  8  
Feb-19  |  132  |  10 
Mar-19  |  76   |  5  
Apr-19  |  57   |  13 
May-19  |  84   |  5  
Jun-19  |  70   |  12 

(Source: NHS England - A&E Waiting times)

The clinical leadership recognised that although the service performed better than the England average for the target of four hours between the decision to admit a patient and the patient being admitted, where patients waited longer than this, this could be for a significant time. They said that this was caused by poor flow throughout (and out of) the hospital as a whole, as well as the significant numbers of patients arriving at the department throughout the day.

From June 2018 to May 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average.

From June 2018 to May 2019 performance against this metric showed an upward trend, peaking in January and February 2019, before falling and stabilising from March to May 2019.

Patients at the trust spend an average of 217 minutes in A&E compared to the England average of 157 minutes. The longest time spend in A&E at the trust was in the winter months of January (236 minutes) and February (234 minutes). The England average time spent in A&E for January and February 2019 was 164 and 165 minutes.

Median total time in A&E per patient - Barking, Havering, and Redbridge University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

There were three bed meetings every day to discuss flow within the hospital which staff from the department attended. In addition, within the service there were two hourly multidisciplinary team “pit stop” meetings, to identify and address bottlenecks in the flow in the department. We had sight of the records of these meetings.

Senior staff attributed the longer stays in the winter months to significant winter pressures both in terms of the number of patients arriving into the department and delays in patients being admitted to other specialties because of bed pressures in those areas.
Whilst the service performed worse than the England average in terms of median length of stay, this was in the face of significant pressures on the department, which is one of the busiest in England with an average of 500 attendees a day. This meant that the department remained busy throughout the year, even outside of the “winter pressures” period. The clinical leadership told us that a significant impact on the number of attendees was the limited availability of primary and community care in the surrounding area. They told us that they had continually highlighted this issue to local commissioners and were working with them to identify key areas of need, which would in turn reduce the number of attendees.

In addition, the clinical leadership expressed concern that the problems in the service were perceived as problems local to the service, rather than the wider hospital taking ownership of the issues and working to alleviate pressure in the service by improving flow in their own specialties and engaging in in-reach into the service, to speed up the turnaround of patients.

**Learning from complaints and concerns**

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

From April 2018 to March 2019 there were 166 complaints about urgent and emergency care at Queen’s Hospital. The trust took an average of 29.3 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be answered within 25 days.

A breakdown of complaints by type is below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>71</td>
<td>42.8%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>20</td>
<td>12.0%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>20</td>
<td>12.0%</td>
</tr>
<tr>
<td>A&amp;E waiting times</td>
<td>14</td>
<td>8.4%</td>
</tr>
<tr>
<td>Communication</td>
<td>14</td>
<td>8.4%</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>8</td>
<td>4.8%</td>
</tr>
<tr>
<td>Medication</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Patient event</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Patient property</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Documentation</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Security</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Infections</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Patient safety</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Privacy, dignity, and discrimination</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>166</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
We had sight of several complaints which had been investigated and responded to. The investigations identified key areas of focus which were agreed with the complainant prior to the investigation. All the complaints we looked at responded appropriately and in full to the concerns raised.

Senior staff told us they were working with colleagues from the hospital wide complaints team to ensure that complaints were responded to in a timely manner in future. This was confirmed by the complaints team.

There were posters throughout the unit signposting patients and their relatives to the trust’s patient liaison service (PALS) with information of how to make a complaint.

From May 2018 to April 2019 there were 49 compliments about urgent and emergency care at the trust, which were all for Queen’s Hospital.

Staff told us that compliments which mentioned them by name were shared with them by the leadership team.

**Is the service well-led?**

**Leadership**

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

In general, staff spoke highly of the local leadership within the service. They described them as approachable and supportive. They said they recognised the difficulties facing staff and were working to address them.

There was a triumvirate leadership team consisting of a matron, a clinical lead and an operations manager for the service. The leadership team were aware of the issues in the department and were proactive in attempting to address them. The service had a strong focus on improvement of management processes and a leadership approach that was highly visible and inclusive.

During our inspection we noticed senior staff were visible in the department and knew ward staff by name.

Most staff told us that they felt supported by the leadership within the service, who they said advocated on their behalf. They said, however, that they did not always feel that the service was supported by the trust-wide senior leadership team.

**Vision and strategy**

Whilst the service subscribed to the trust’s overall vision and values, there was no unique vision for the service itself.
The trust had a tool called the PRIDE Way which was used in the development of all new policies and procedures to ensure they reflected the values of the trust. Some staff we spoke with told us that the PRIDE Way was primarily used by managerial staff and was not always reflected in practice.

Whilst there was no formal vision for the service, senior leaders made clear that their aim was for the service was meet the demand of the population and to reduce pressure on the service. The strategy for doing so was to work with the wider trust and wider healthcare economy. Staff we spoke with were aware of this.

Culture

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

Staff were positive about working within the service. They were confident in the service leadership to support them to provide the best possible care for patients. However, a number of staff expressed concern that the service was isolated within the wider hospital community.

Governance

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

There was an effective governance system in place in the service. Senior leaders were aware of the issues faced by the service and were aware when incidents occurred.

The department held joint governance meetings with the local mental health trust, to discuss governance issues relating to the care of mental health patients and collaborative working between the two services.

There were daily meetings to discuss incidents which fed into a weekly meeting. The weekly clinical governance meeting took place to discuss serious incidents and other departmental issues. At this meeting the team looked for any trends from incidents in the department.

The clinical governance meeting fed into the weekly divisional meeting. There was also a monthly quality safety meeting where items such as national audits, evidenced based guidelines and complaints were discussed.

There were monthly meetings joint governance meetings with the local mental health trust, to discuss issues relating to mental health patients in the department.

Management of risk, issues and performance

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

There was an acute medical services risk register, which included all risks related to the service. The risk register included details of risks. However, whilst it included review dates, it did not record mitigating actions taken in response to each of the risks. Risks were rated from one to four, with one...
being low and four extreme. We had sight of the risk register as of June 2019, where the top rate risks related to nurse staffing, prolonged stays on the unit by paediatric mental health patients and the failure to meet the four-hour target.

The risk register was a standing agenda item at the monthly quality and safety meetings. Senior staff told us that these meetings were well attended. In addition to the risk register, they discussed recent incidents and learning from incidents, complaints, investigations and safeguarding issues.

The service had a specialty improvement plan to improve the time it took for specialities to respond to a request for a patient review. The service recorded percentage of patients reviewed by each speciality within 30 minutes. This was discussed at the divisional governance meetings and a daily email was sent to each speciality highlighting the results.

The directorate had a robust audit programme, which was used to monitor services and compliance against national and local standards.

There was an emergency medicine network with other hospitals in which key information and learning was shared.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service was able to map performance in real time across a 24-hour period.

This information was used to predict capacity in the unit at a given time and to assist in rota planning for forthcoming weeks by identifying trends. The information was also used retrospectively to identify four-hour breaches and to track the performance of the service against other targets at governance meetings.

In the RAFTing area there was a live screen which tracked ambulance patients' journey from the ambulance call being made to the patient being admitted into the hospital. This provided information such as the condition for which the patient was being brought to hospital, their comorbidities and expected time of arrival. Nursing staff told us they used this to ensure relevant staff were present in time for a patient’s arrival, where possible.

Some medical staff highlighted a shortage of computer stations. In addition, all staff expressed frustration at the IT systems. Senior leaders accepted that the trust as a whole faced IT infrastructure problems due to lack of investment. They told us that this was recognised by the trust’s leadership and there were longer term plans to improve this.

Engagement

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

There was a ‘you said, we did’ board displayed in the corridor which included details of changes made in response to feedback. There was also a ‘you said, we did board’ in the paediatric area.
There were information boards displayed in patient waiting areas, detailing common care pathways and displaying information about audits such as hand hygiene and infection control displayed in patient waiting areas.

Nursing staff said they received regular updates from the sisters detailing recent incidents and learning and development opportunities. All staff were also invited to weekly clinical governance meetings to get updates about the department. There were also information boards regarding incidents, performance and safeguarding issues displayed in staff areas.

Learning, continuous improvement and innovation

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

The service had an academy of emergency medicine.

In addition, the regional director for emergency medicine worked within the unit, which was a recognised research unit.

The service was undertaking a joint research project into the use of artificial intelligence in urgent and emergency medicine with a nationally recognised data science institute.

Junior medical staff and trainee ANPs and ACPs described a positive learning environment in the unit. They told us that the number of consultants and the 24-hour consultant cover meant that they were able to provide “opportunistic teaching” in addition to traditional teaching on ward rounds. Staff described this as hugely beneficial.

Queen’s Hospital

Critical care

Facts and data about this service

The trust has 63 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type at Barking, Havering and Redbridge University Hospitals NHS Trust and England.

This trust: England:

(Source: NHS England)
Queen's Hospital

Queen's Hospital has three critical care wards; a general intensive care and high dependency unit, a coronary care unit, and a neuro-intensive therapy and high dependency unit (NITU).

The service at the Hospital is designed to accommodate patients with level two (high dependency) and level three (intensive care) needs. Level two care describes patients requiring more detailed observation or intervention. This includes support for a single failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure.

There are 46 critical care beds at Queens Hospital. The general intensive care unit (GICU) and high dependency unit (GHDU) where there are 24 beds allocated to general intensive care. There is also the 12 bedded neuro ITU (NITU) which is made up of six intensive care beds and six high dependency bed.

These wards are collocated on the ground floor of the hospital, and all beds on these wards can accommodate level 2 and level 3 patients. Since the last inspection, there are a further 10 general high dependency beds opened on Sky A on the fourth floor.

The trust has a consultant led critical care outreach team (CCOT) delivered by specialist nurses to support the needs of acute and deteriorating ward and emergency patients on both sites.

The critical care provision is led by a mix of general and neuro intensivists. The nursing provision consisted of general ICU nurses, specialist neuro-ITU nurses, and healthcare assistants. Critical care wards also had access to physiotherapists, speech therapists, dieticians, and pharmacy support.

As at March 2019, the intensive treatment unit had 84.4 nursing WTE staff, 15.0 other clinical WTE staff and 3.8 administrative and clerical WTE staff. The NITU had 48.7 nursing WTE staff, 4.2 other clinical WTE staff and 1.7 administrative and clerical WTE staff.

(Source: Routine Provider Information Request (RPIR) Acute – Context tab)

Immediate family and friends can visit patients from 6am to 3pm and from 5pm to 9pm. This is protected resting time for patients between 3pm and 5pm.

We visited all critical care wards over three days during our announced inspection on the 3 September to 5 September 2019

We reviewed 10 patient care records and observed care being provided. We spoke with 4 relatives and carers, 6 patients and 35 members of staff including nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians, and administrative staff. We also reviewed the trust’s performance data and looked at trust policies for critical care.
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. However, we identified some areas where staff had not completed it, such as resuscitation training.

Critical care staff were not meeting the trust target in mandatory training modules for resuscitation level 2 and 3. Data provided by the trust between April and June 2019 showed the compliance rate for resuscitation level 3 (adult immediate life support) for medical staff in critical care was 51.7% against trust target of 90%. The critical care leadership recognised this as an issue, and resuscitation training was included on the divisional risk register. Senior staff stated that availability of courses and availability of staff to attend training were factors impacting on compliance rates for training. Following inspection, the trust provided updated figures for compliance, showing resuscitation training for nurses at 97% for Level 2 and 86% for Level 3, while medical staff were at 69% compliant for Level 2.

The trust set a target of 90% for completion of all mandatory training courses except for information governance which has a target of 95%.

Medical staff worked across both sites. The trust did not report mandatory training completion rates for medical staff at site level. A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>24</td>
</tr>
<tr>
<td>Fire safety</td>
<td>52</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>47</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>47</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>46</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>46</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>44</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>44</td>
</tr>
<tr>
<td>Information governance</td>
<td>43</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>43</td>
</tr>
<tr>
<td>Resuscitation level 2 - paediatric basic life support</td>
<td>14</td>
</tr>
</tbody>
</table>

Trust level data showed that critical care met the target for two of the eleven mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April to June 2019 for qualified nursing staff in the critical care department at Queen’s Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>24</td>
</tr>
<tr>
<td>Fire safety</td>
<td>52</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>47</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>47</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>46</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>46</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>44</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>44</td>
</tr>
<tr>
<td>Information governance</td>
<td>43</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>43</td>
</tr>
<tr>
<td>Resuscitation level 2 - paediatric basic life support</td>
<td>14</td>
</tr>
</tbody>
</table>
Queen’s Hospital critical care department met the target for nine of the 12 mandatory training modules for which qualified nursing staff were eligible.

The trust reported compliance for mandatory training courses for qualified nursing staff, that work across both sites, under a separate trust wide section.

A breakdown of compliance for mandatory training courses from April to June 2019 for qualified nursing staff in critical care that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>11</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>11</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>11</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>11</td>
</tr>
<tr>
<td>Information governance</td>
<td>11</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>11</td>
</tr>
<tr>
<td>Resuscitation level 3 - adult immediate life support</td>
<td>11</td>
</tr>
</tbody>
</table>

Qualified nursing staff, working across the critical care department at both sites, met the target for all nine mandatory training modules for which qualified nursing staff were eligible.

However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training modules were a mix of classroom delivered training and e-learning. Staff were able to access and complete training modules remotely and would receive the time back. Staff
stated they while this generally worked well, it could occasionally be difficult to access the e-learning system from home.

Staff completion of mandatory training modules was monitored by managers through the trust training system. Staff would be informed when training was due to expire, and they would be required to book on to the next available training.

Safeguarding

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

Medical staff worked across both sites. The trust did not report safeguarding training completion rates for medical staff at site level. A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>49</td>
<td>56</td>
<td>87.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>48</td>
<td>56</td>
<td>85.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Critical care did not meet their own target for any safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 for qualified nursing staff in the critical care department at Queen’s Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>112</td>
<td>114</td>
<td>98.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>130</td>
<td>135</td>
<td>96.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 3</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Queen’s Hospital critical care department met the target for all safeguarding training modules for which qualified nursing staff were eligible.

The trust reported compliance for safeguarding training courses for qualified nursing staff that work across both sites, under a separate trust wide section.

A breakdown of compliance for safeguarding training courses from April to June 2019 for qualified nursing staff in critical care, that work across both sites, is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing staff within critical care, working across both sites, met the target for both safeguarding training modules for which they were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff had a good understanding of when they would need to report safeguarding issues and who they would contact in the event of any concerns. Staff were aware of the trust safeguarding team, and there were posters up in clinical areas displaying contact details for safeguarding leads.

Staff reported issues using the safeguarding adults form. All safeguarding forms were shared with the local authority of the relevant borough, as well as with the trust safeguarding team. The safeguarding forms contained contact details for the trust safeguarding team and for each local authority in the area.

Staff were aware of specific safeguarding risks to patients, such as female genital mutilation (FGM). Staff members we spoke with were able to demonstrate consistent awareness of FGM and how it should be reported.

We reviewed the hospital safeguarding policy, which detailed what to do in the event of a safeguarding concern and reflected the service’s obligations under safeguarding legislation. We also reviewed examples of safeguarding investigations, which were carried out in critical care by senior staff, and investigations complied with the safeguarding policy.

Cleanliness, infection control and hygiene

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

All areas we checked were visibly clean with minimal clutter in corridors or clinical areas. The service used ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use. All the equipment we checked were clean and the date was recorded with an ‘I am clean’ sticker. Equipment was also checked and audited regularly.

The ITU provided staff with personal protective equipment (PPE) such as gloves and aprons. Each patient bedside area used a specific colour of PPE to identify if staff had changed their aprons or gloves before moving between patients, in line with best practice for infection prevention and control (IPC). However, we observed inconsistent use of this process on clinical wards, as some staff moved between patient areas using the same aprons and gloves, or did not use aprons and gloves at all. Senior staff stated that any staff who were observed not meeting the critical care IPC practices would be reminded of their responsibilities if necessary.

We observed inconsistent staff compliance with IPC best practice guidance in relation to hand hygiene and ‘bare below the elbows’ protocols. Some staff in clinical areas were noted to not clean their hands between patient interactions, while some staff (including non-ward based staff) were not bare below the elbow. However, we observed ward staff, on occasion, challenge colleagues who were not complying with these protocols.

Entrances to the wards and clinical areas had hand sanitising gel dispensers. We observed staff and visitors using these on the wards. Some alcohol gel dispensers on the critical care wards were also observed to be empty and not changed throughout the day.
Cleaning schedules were used to monitor the completion of daily, weekly, and monthly infection prevention and control tasks. Cleaning was completed by a mix of staff in clinical areas and cleaners from a third-party provider. We observed these tasks being carried out, such as cleaning of bed areas once a patient had been discharged. Staff on the wards were positive about the quality of cleaning provided by domestic staff.

Waste was separated and disposed of in line with best practice guidance relating to clinical waste and sharps. Staff were informed of local arrangements relating to clinical waste disposal and sharps bins.

Hospital wards had a suitable control of substances hazardous to health (COSHH) policy and procedures in place for staff to follow. COSHH risk assessments were undertaken, and the service ensured compliance with COSHH arrangements through monitoring. For example, hazardous substances and materials were kept in secured areas only accessible by staff.

Critical care wards had IPC link nurses who were assigned to monitor clinical compliance with IPC practices on the wards, such as hand hygiene, use of PPE, and decontamination of equipment. Audits (carried out by the trust IPC team) provided by the trust for 2019 showed 100% compliance for IPC practices on critical care wards. IPC audits were not identifying issues with hand hygiene compliance as we observed on inspection.

The wards had notice boards dedicated to IPC performance in critical care areas. The boards included information for staff on IPC guidelines, as well as performance in relation to screening patients for transmittable infections, such as Methicillin-resistant Staphylococcus aureus (MRSA) and Carbapenamase producing Enterobacteriaceae (CPE). All patient records we reviewed showed evidence of screening for these infection risks on admission to critical care wards.

In the period between March and August 2019, the service reported no cases of Hospital acquired MRSA, CPE, or Clostridium difficile (C. difficile).

We observed isolation protocols in place for patients with infections by using the side rooms. Staff told us that in event of a patient needing to be isolated, the side room would be marked clearly to alert staff and visitors with instructions of the precautions to take prior to entering the side room. We observed staff adhering to these practices.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment kept people safe.
Staff managed clinical waste well. Some for the critical care wards were not meeting national standards for critical care environments

The critical care provision was separated into three wards: a 22 bedded general intensive care unit (GICU), a 12 bedded neuro intensive care unit (NICU), and a ten bedded intensive care unit on Sky A ward (which had opened since the last inspection). Each ward was capable of managing level two and level three patients (excluding Sky A which managed level 2 patients), and there were side rooms in each area to manage patients in isolation.

The GICU and NICU wards were designed prior to the building regulations for critical care units (HBN 04-02) and as such had areas where they were not compliant with this regulation (as identified at previous inspection). On this inspection, we requested evidence that Sky A complied with the HBN 04-02 building regulations. The trust provided evidence of consideration of environmental factors and risk assessments for Sky A, however identified some areas where they were not compliant with HBN
04-02. This included no uninterruptible power supply (UPS) on the ward, bed spacing, and sufficient lighting. The trust stated that further action is required, and Sky A compliance with building regulations was now added to the divisional risk register.

Emergency equipment such as a resuscitation and emergency intubation trolleys and crash bags were available. Staff checked resuscitation equipment daily in line with guidance from the Resuscitation Council. We also observed blue critical care transfer bags in each clinical area which were regularly checked.

Entrances to critical care wards were controlled by security card, and visitors were required to identify themselves by using the intercom to staff before being granted entry. We observed these systems be used consistently.

We observed that electrical equipment displayed the date of the last electrical testing, and any equipment that required servicing was in date. Staff stated that where equipment was not working, maintenance was organised quickly to provide repair. Staff also stated the hospital was quick to address any environmental or equipment issues identified.

Senior staff stated that some equipment on the ward would be due for replacement shortly. However, since inspection there had been significant investment in critical care wards. This included equipment for the fourth floor HDU (Sky A), pendant mounted ventilators, and new patient monitoring systems.

At the time of the last inspection we identified that the meeting rooms for handovers and team meetings were held in small rooms, which could make it difficult for all staff to attend and contribute. Critical care leadership had since moved the meetings to a larger room adjacent to the surgery departments. This allowed more staff to attend.

At the time of the last inspection we identified that there was limited storage space and surplus equipment was stored in empty bed bays. On this inspection, critical care wards were limited in terms of space but were well organised and clutter free (although staff acknowledged store rooms could be cluttered).

Staff appropriately escalated any mixed sex breaches to critical care leadership. The senior leadership team stated that as soon as the patient was stepped down to go to the ward, the consultant was informed. Staff took a multidisciplinary approach to ensure any risks or safety concerns were mitigated for each breach. Senior leadership stated that they would accommodate single sex accommodations on wards most of the time but managing the clinical risk of patients across the hospital would be the priority.

**Assessing and responding to patient risk**

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

Staff used the national early warning scores (NEWS) system to assess and monitor deterioration in patients, which were kept at the patient bedside. We saw the NEWS form used by staff to monitor any deterioration in the patient’s status, and observed staff discussing the NEWS score when deciding on care plans.

A VTE risk assessment tool was included in the patient records, and compliance for assessment was audited regularly by ITU. Compliance for patients being risk assessed for VTE was 100%. On inspection we viewed patient records and they demonstrated that all patients had undergone VTE assessments on admission.
The critical care service had pathways in place for patients at risk of deterioration. Staff we spoke with were aware of the actions taken when there were signs that a patient was deteriorating, and the pathways were posted on notice boards in the ITU. This included pathways for sepsis, resuscitation, and anaphylaxis.

Management of sepsis on critical care wards was in accordance with the hospital’s policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis guidance on the management of septic patients, and we saw evidence of screening in patient records we reviewed. The ‘Sepsis Six’ approach was used, sepsis training was mandatory, and the sepsis pathway was visible on notice boards across critical care wards. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

Critical care staff were trained and had the equipment to manage tracheostomy patients. Tracheostomy patients were observed to have emergency trays in their rooms for urgent replacement of tracheostomy tubes if necessary, in line with best practice. However patient records did not have routine risk assessments for monitoring tracheostomy cuff inflation. Cuff over-inflation can result in trauma or necrosis around the tracheostomy. We also found that forms which identify patients who have a tracheostomy prior to admission were not consistently used in patient records. The CCOT lead a weekly trust tracheostomy ward round’ to support the delivery of care to patients with tracheostomy in non-critical care areas.

The trust produced public information leaflets for managing risks to patients on wards. This included leaflets on infection control, sepsis screening, falls prevention, and pressure ulcer management.

Any tissue viability concerns could be reported to the hospital tissue viability nurses (TVN) for support and advice, particularly managing any complex pressure ulcers. Staff stated they were well supported to manged pressure ulcers, and any concerns could be presented at the weekly tissue viability meetings. TVNs had also provided some on-ward training in the past.

The critical care outreach team (CCOT) supported acutely unwell patients in other areas of the hospital, prior to their transfer to the critical care, and to follow up with discharged critical care patients. The CCOT was consultant-led with one lead nurse (band 8a) and nine outreach nurses (band 7). The CCOT provided cover seven days a week from 7.30am to 8pm. CCOT attended the morning handover with critical care wards and provided an evening handover to the clinical site managers.

We identified on inspection that staff compliance with resuscitation training was not meeting the trust target, and at the time of data requests was as low as 50%. Critical care wards had plans in place to call the emergency crash team, and staff were aware of how to access this service when needed. Crash teams were able to access emergency equipment on the wards but also provided their own kits including intubation equipment, ventilator, and emergency medications.

Since the time of the last inspection the critical care provision had expanded to include an additional ward on the fourth floor of the hospital (Sky A). This area did not have any inflatable mattresses for emergency transfer of patients in the event of a fire, meaning that any evacuation would be dependent on elevators. Staff we spoke with were unaware of any fire assessment or equipment relating to Sky A.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and
Managers regularly reviewed staffing levels and skill mix, and gave agency staff a full induction. There were significant vacancies in nursing staffing but critical care wards were mitigating this risk as much as possible.

The table below shows a summary of the nursing staffing metrics within critical care at Queen’s Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>262.7</td>
<td>16.3%</td>
<td>16.6%</td>
<td>23.2%</td>
<td>44,778.8 (10.3%)</td>
<td>28,218.2 (6.5%)</td>
<td>16,599 (3.8%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>173.9</td>
<td>20.5%</td>
<td>18.3%</td>
<td>23.6%</td>
<td>23.2%</td>
<td>18.3%</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within critical care Queen’s Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and agency staff use.

Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. (Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from November 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

We were told that the trust had taken action in response to high sickness rates. However, they did not indicate how sickness rates had improved.

Bank staff usage

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

The trust’s critical care service was managed by a matron (covering both sites) who reported into the divisional director of nursing. Staff we spoke with were positive about the approach and availability of both the local and divisional nursing leadership.

Each critical care ward had a senior sister in charge of the ward. The NICU senior sister was supported by a deputy, however there was no deputy in place for the GITU. This meant that when the sister for GITU was unavailable, senior staff would be allocated individual tasks of responsibility, however as there was no nominated lead, oversight for the ward was less structured in the absence of the senior sister.
The Faculty of Intensive Care Medicine (FICM) Core Standards for Intensive Care Units states that all level three (patients requiring advanced respiratory support alone or basic respiratory support with support of two other organ systems) patients are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care. For level two (patients requiring more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure) patients a ratio of 1:2 is required. We reviewed patient allocation records and staffing during our inspection which showed the critical care wards complied with the required staffing levels.

FICM Core Standards suggested a minimum of 50% of registered nursing staff should be in possession of a post registration award in critical care nursing on wards. Data provided by the ward leaders on the inspection showed 71% of GITU staff and 67% of NITU staff were meeting this criteria for post registration qualifications.

Critical care wards at Queens Hospital had developed a predictive model of staffing, based on demand in the past, to inform required staffing levels throughout the year. This meant that the critical service could be proactive in judging when they would need increased levels of staffing. Nursing provision in critical care was also reviewed throughout the day. Senior staff identified if there was any need for additional staff, and this could be arranged as necessary. Monitoring of staffing levels was handed over to the site manager during night shifts.

Staff we spoke with stated that the service used bank staff where possible, instead of agency staff, as they would be more familiar with the ward and could deliver more continuity of care. Critical care wards had increased the rate of pay for bank shifts, particularly during times of increased activity, to encourage this, and staff stated it had a noticeable impact.

The FICM Core Standards recommends no more than 20% agency staff usage per shift. Data provided by the trust showed that agency staff use on the unit had been 6.5% between April 2018 to March 2019 which was compliant with the FICM standard.

Senior staff we spoke with stated that staffing levels had improved since the time of the last inspection, however recognised that is was a constant difficulty to keep staffing levels stable. Senior staff recognised that opening a new critical ward had also impacted nursing figures. Critical care wards were due to take on several new international nurses from a recent recruitment drive, and regularly reviewed what additional benefits could be offered to attract staff. Senior staff stated factors impacting the critical care workforce included the outer London pay weighting, and nurses leaving to pursue leadership roles elsewhere.

At times of high activity, staff from the critical care outreach team (CCOT) may be required to provide cover on the wards. Staff stated that this had been a difficult transition for some staff, however leadership stated that it had much improved since voluntary agreement for the arrangement was sought from CCOT staff.

Nursing shifts on each critical care ward were supported by a healthcare assistant (HCA). Although nursing staff we were positive about the contribution of the HCAs, they stated that HCAs were often stretch very thin on shifts, particularly on GITU/GHDU. HCAs we spoke with stated they enjoyed the role and the care they provided, but recognised they were very busy on shifts.

Nursing staff worked shifts from 7.30am to 8.00pm, nightshifts from 7.30pm to 8.00am, late shift from 12.00 to 8pm and some staff did a short shift 7.30am to 3.30pm. Nursing staff had two handovers each day. We attended a nurse handover and found it was detailed and structured.

Nursing staff stated they had regular team meetings to review clinical practice and performance, and to review any arising issues. Band 7s also stated they held a critical care leadership meeting every two months.
Medical staffing

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

The table below shows a summary of the medical staffing metrics within critical care at trust level compared to the trust’s targets, where applicable. Medical staff work across both sites. The trust reported staffing metrics for medical staff only at trust level.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>306.3</td>
<td>17.6%</td>
<td>16.5%</td>
<td>24.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>62.1</td>
<td>4.4%</td>
<td>13.3%</td>
<td>15.0%</td>
<td>6,761.5</td>
<td>36.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>

The trust did not supply the total available hours for medical staff. We could therefore not calculate rates for bank, agency, and hours unfilled. *(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

Medical staffing rates within critical care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness.

Vacancy rates

Monthly vacancy rates over the last 12 months for medical staff showed a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

Monthly turnover rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
Oversight for medical staffing in critical care wards was provided by the clinical lead. The clinical lead in post was due to step down from their role to be replaced by their deputy clinical lead. Staff we spoke with stated medical leadership was visible on the wards and assessible when needed, and that the deputy clinical lead stepping up into the clinical lead role would provide continuity of leadership to critical care medical staff.

Consultants were available on all critical care wards every day by 8am and 6pm, with further consultant cover provided between 3pm and 11pm daily. Out of these hours cover was provided by two consultants available remotely for telephone advice and, if needed, to attend the wards. Junior doctors told us they could easily contact the on-call doctors if needed for support.

Consultants were supported on critical care wards by a range of specialist trainees, foundation year 2 doctors, and core trainees. During the daytime shift (8am to 6pm), a registrar supported the critical care consultant on each ward. Overnight, a registrar was responsible for each critical care ward with support available from call consultants if needed.

Staff stated there was a positive relationship between the consultants and junior medical staff. Junior staff felt well supported, and consultant were positive about the quality of trainees they worked with. Staff also stated that if there were gaps in the junior doctors’ rota, consultants could provide cover.

Medical handover meetings took place every morning at 8am, and consisted of medical staff from each ward, nursing staff, and the CCOT. Doctors on duty overnight updated the day shift team on any new patients, changes or concerns, and any patients due who could be stepped down. We observed a morning handover on inspection and found it to be well managed.

Doctors completed a formal ward round twice each day and decided upon a management plan for each patient; this was in line with recommendations by the FICM Core Standards for Intensive Care Units. However, evidence of the evening ward round was not always formally documented in the patient records. We observed ward rounds on inspection and found them to be well attended, with input from not only medical staff but other clinical disciplines. Ward rounds also included opportunities for junior doctors to present patients.

Critical care wards provided opportunities for international recruits and speciality courses. For example, some medical staff had successfully completed the Certificate of Eligibility for Specialist Registration (CESR) programme and been appointed to substantive roles with the trust. CESR is the alternative route of becoming a fully qualified specialist in the UK. Critical care wards also had several overseas senior doctors with anaesthetic backgrounds, staff from Medical Trainee Initiatives (MTI) and international fellows.

Critical care wards had recently taken on a number of new recruits as Advanced Critical Care Practitioners (ACCPs). This role provided support for medical staff, and also provided developmental opportunities for experienced healthcare staff. ACCPs attended both critical care university courses and spent time gaining clinical experience on the wards. Supervision was provided by consultants, and ACCPs were provided with a guaranteed post within critical care at the end of their training. Medical staff we spoke with stated that the ACCPs were very new to the wards, but were positive about the contribution they were making.

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

Patient records for critical care patients were completed in paper form, and the service used patient risk assessment booklet which had been developed by the trust. At the time of the last inspection we
found inconsistencies in record completion. Patient records on this occasion were legible and comprehensively completed. All records had detailed notes of the patient care from different disciplines, treatment plans, completed risk assessments, and results of any diagnostic tests the patient had received.

Patients’ observation charts were kept by the patient’s bedside or just outside their rooms, and staff would input data at regular intervals. Once completed for the day it would be filed in the patient’s records.

Information governance was part of mandatory training for all staff. The hospital also had a management of health records policy detailing the process for managing and completing patient records. However, we observed staff leaving patient case notes unattended on critical care wards, which did not comply with the information governance practices for the trust or best practice.

Critical care wards did not have a clinical information system, and staff recognised this as a frustration for sharing information quickly, for investigating incidents, and for audit purposes. The rest of the hospital used electronic patient records systems, which meant staff could be required to transfer information between systems when patients were admitted or discharged to another ward. The critical care leadership had submitted a business case with the trust to acquire an electronic system, however this was still underway. The CCOT used an electronic database to record their outreach reviews and printed paper copies for the patients records.

Where patients were discharged or transferred out of the unit, there was a specific handover sheet / discharge summary from the medical team and a separate one for nursing staff. We checked one discharge summary for a patient discharged during the inspection and found it was fully complete, contained all necessary information and was easy to understand.

Patient records in critical care did not include routine evidence of an evening or night ward round, in line with best practice. We observed routine recording of morning handovers, including MDT input, in the patient records, however evidence of a second ward round was not recorded in the same way.

**Medicines**

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

Critical care wards had access to specialist pharmacy input that cover both trust hospital site. Critical care pharmacy staff were either specialist in their roles or had received critical care training. Dedicated critical care pharmacists worked from 9am to 5pm Monday to Friday, and on weekends between 9am to 5pm. Out of these hours, staff could access support from the on-call site pharmacist.

Specialist critical care pharmacists were involved in ward rounds and morning meetings as required. We observed pharmacy staff attending these meetings and liaising with ward staff. Critical care staff we spoke with felt they were well supported by the pharmacy team.

At the time of the last inspection there were inconsistencies in completion of drug charts and prescriptions. We reviewed medication charts in patient records and found them to be consistently completed. The critical care service used a speciality drug chart, which was developed collaboratively between the pharmacy team and critical care. Staff documented information patient medication risks as necessary. We found that prescription charts were legible and showed review by pharmacists where needed.
Pharmacists were responsible for reviewing medicine charts to check prescriptions were correct. Pharmacists completed medicines reconciliation within 24 hours. Medicines reconciliation is the process of identifying the most accurate list of all medicines that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medicines obtained from a patient, or GP.

Medicines were administered and secured securely in accordance with the medicines management policy of the hospital. The service had access to a provider wide specialist pharmacy advisor who supported compliance with legislation and best practice.

The unit used an autonomous computerised cabinet (Omnicell) to store intravenous equipment such as blood administration sets. The cabinet was accessed by staff fingerprint and had a system to track stock levels with the stores department in the hospital. Staff stated that this system worked well. Pharmacy staff we spoke with stated that where there were medication or equipment shortages this would be communicated by bulletin or in meetings.

The pharmacy and critical care team had run several collaborative improvement projects to improve the delivery of care. For example, the pharmacy team provided pre-filled syringes or pre-prepared medications for some drugs, as this reduced the risk of incorrect doses. The service had also invested in intravenous infusion pumps with drug libraries that match infusion charts. Senior staff stated that these improvement exercises had improved practice for staff, and some of the improvements had been presented at conferences for the European Society of Intensive Care Medicine (ESICM).

Controlled drugs were stored and managed appropriately. Drugs were kept in lockable units and staff performed twice daily checks of the controlled drugs to ensure they were accounted for.

Medicines requiring cool storage were appropriately stored in refrigerators. Fridge temperatures, as well as the temperature in the medication room, were recorded daily. Staff were aware of the escalation procedure when fridge temperatures were outside of the normal range.

Patients were assessed for any potential allergies to clinical equipment or medications on admission. We observed allergy assessments completed in the patient record.

Medication errors were reported and investigated as incidents. Staff we spoke with stated that, depending on the type of incident, medication errors would be investigated with input from both pharmacy and critical care staff. Staff stated that they received feedback on incidents related to medication.

The pharmacy team had a programme of monthly medicine audits to ensure compliance with legislation and best practice. This included audits of safe storage of medication, controlled drugs, review of medication charts, and prescribing. Pharmacists had also completed recent bespoke audits for critical care, including for availability of resuscitation medication.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2018 to May 2019, the trust did not report any never events for critical care at Queens Hospital. (Source: Strategic Executive Information System (STEIS))

At the time of inspection, a never event was identified at the other trust hospital site in critical care relating to a retained foreign object (a guide wire in a central venous catheter). This never event was similar to a number of similar incidents that had occurred between May and July of 2018. At the time of the 2018 never events, the trust put in place a number of Local Safety Standards for Invasive Procedures (LocSSIPs) to minimise the risk of the never event occurring. However, staff we spoke with on inspection were unaware of LocSSIPs or national guidance in place to minimise the risk of retained guide wires. Senior leads informed inspectors that policies were in place on the intranet since February 2018, although inspectors found they could not be located easily, and were not immediately available to critical care staff.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2018 to May 2019. Both incidents took place at Queen’s Hospital. One was a medication incident and the other a pressure ulcer incident both meeting SI criteria. (Source: Strategic Executive Information System (STEIS))

At the time of the last inspection we found there was limited use of systems to record and report safety concerns and incidents. Some staff were also unclear about the types of incident to report and were wary about raising concerns. On this inspection there was an electronic incident reporting system was in place across the trust and staff knew how to report an incident. Staff told us they also received feedback from incidents reported that were investigated, either through team meetings, safety huddles, or by email.

Staff were aware of the principles of duty of candour and when it would be applied. Staff also stated they felt encouraged to report incidents if they identified concerns. The incident policy reflected the hospital’s requirement to be open and transparent with patients when there had been an incident and outlined the procedure by which patients would be involved or informed in the investigation process. We saw this reflected in investigations of serious incidents we reviewed.

Incidents were monitored by senior staff and depending on the type of incident, investigated to identify areas for improvement. Staff stated that use of paper records made it more difficult to gather information for incident investigation. The hospital incident policy described the process to be followed when investigating incidents. Incidents were investigated by a nominated individual and reviewed in governance meetings locally. We reviewed incident reports from the last twelve months and found them to be comprehensively investigated and reviewed.

The service held daily meetings of critical care staff and service managers to share information on incidents, transfers of patients, staffing issues and any other issues that may impact the delivery of care. Incidents were also discussed in regular team and divisional meetings, which were minuted for staff who could not attend. Staff stated they were generally well informed about incidents and investigations relating to critical care wards across the trust.

The service had a business continuity plan in place and staff were generally aware of this process on critical care wards. The trust recently held a scenario training exercise for a large-scale emergency event to test the capability of response services, and to identify where contingency plans could be improved.
Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and three new catheter urinary tract infections (UTIs) from May 2018 to May 2019. (Source: NHS Digital). Updated information following inspection showed no further changes in the data.

We saw the Safety Thermometer data displayed on the quality of care board on critical care wards. Information leaflets on falls, pressure ulcers, and UTIs were also located close to the safety thermometer data on each ward.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines. Staff followed national and local guidelines and standards to ensure effective and safe care. National best practice was reflected in the policies we reviewed.

Staff assessed patients’ needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. Delivery of care on critical care wards was informed by standards and recommendations in the Guidelines for the Provision of Intensive Care Services (GPICS), developed by the Faculty of Intensive Care Medicine (FICM).

Staff had access to the trust policies and guidelines via an intranet. Paper copies of local protocols and policies were also available to staff. All protocols and guidelines we reviewed were in date. We also saw evidence where protocols and pathways were amended following newly identified risks or service need.

Care was delivered in line with best practice for treating critical care patients. Patients were monitored using the National Early Warning Score (NEWS), and the wards followed the Sepsis Trust guidance on the initial management of septic patients and used the ‘Sepsis Six’ approach as recommended to provide consistent care.

The service also contributed and uploaded data regularly to the Intensive Care National Audit Research Centre (ICNARC), which provides information/feedback about the quality of care to those who work in critical care to allow service benchmarking against similar critical care units nationally.

The service actively engaged with the local critical care network to help support and improve delivery of high-quality care in the area. As members of the North East North Central London Adult Critical Care Network (NENCL), senior staff participated in regular meetings and shared feedback from these with staff. The clinical lead for critical care services at the trust was the NENCL lead for peer review.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

At the time of the last inspection, critical care wards did not have dedicated input from dieticians. Critical care wards now had full-time dieticians in post in both general and neuro intensive care wards. Staff we spoke with were very positive about the input of dieticians, who could attend ward rounds for patients, and provide advice and support as needed.

Dietician posts were funded out of the critical care post and managed by the matron for critical care. Staff we spoke with stated this allowed dieticians to be very clinically focused and familiar with the ward, as opposed only being able to offer advice remotely and visiting the ward infrequently. Dieticians were also available to support the Critical care Outreach Team (CCOT) if needed.
Dieticians stated they carried out a number of audits on critical care wards to monitor the delivery of their service. This included regular audits of patient records and review of complex cases, and bespoke audits such as protein supplementation in acutely unwell patients. Dieticians also attended the weekly critical care governance meetings, as well as the hospital nutrition advisory group.

Staff made sure patients had support with nutrition and hydration to meet their needs. The ITU had access to a dietitian who could assess new patient’s dietary needs as necessary. Staff told us that the dietician was available to provide advice and support if needed.

We reviewed patient records on inspection and found that the nutritional needs of patients was monitored using the Malnutritional Screening Tool (MUST). Records reflected the use of fluid balance charts for each patient, as well as evidence of intravenous feeding when patients were not eating or drinking.

We observed patients being provided with meals, and visitors to the wards being offered refreshments by staff. Patients we spoke with were positive about the food and stated there was options to meet any dietary or religious requirements. Lunch and evening meal times were protected.

**Pain relief**

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

We observed staff on the wards discussing pain management with patients. Patients stated that they felt their pain relief was discussed as part of their care, and we saw this reflected in the patient records. We observed staff communicating with non-verbal patients using visual cues.

The trust had a specialist pain management team to provide advice and support to staff regarding pain relief for patients. The pain team included a specialist practitioner nurse, two clinical nurse specialists and two sisters. Staff stated they were aware of how to access the team. The pain management service was available seven days a week, with anaesthetic consultant cover out of hours.

Critical care wards also had a dedicated link nurse for pain management which staff were aware of.

**Patient outcomes**

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

The trust has three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 annual report. Any available quarterly data should be considered alongside this annual data. *(Source: Intensive Care National Audit Research Centre (ICNARC))*

The table below summarises performance at the general intensive therapy and high dependency unit at Queen's Hospital in the 2017/18 ICNARC Audit.
The table below summarises performance at the neuro-intensive therapy unit and high dependency unit at Queen's Hospital in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crude non-clinical transfers</strong> (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.4%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude, non-delayed, out-of-hours discharge to the ward proportion</strong> (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>0.6%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)</strong> (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>0.9%</td>
<td>Not in the worst 5% of units</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Risk-adjusted hospital mortality ratio (all patients)</strong> (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.1</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients)</strong> (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.2</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
Risk-adjusted hospital mortality ratio (all patients)  
(Risk-adjusted measures take into account the differences in the case-mix of patients treated)  
1.3  
Within expected range  
No current standard

Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients)  
(Risk-adjusted measures take into account the differences in the case-mix of patients treated)  
1.7  
Within expected limits  
No current standard

(Source: Intensive Care National Audit Research Centre (ICNARC))

The service submitted data to the Intensive Care National Audit & Research Centre (ICNARC) for all patients treated within the intensive care setting. This meant care delivered and patient outcomes were benchmarked against similar units nationally.

Each critical care ward at Queens Hospital had nursing staff with dedicated time to collect ICNARC data once a week. We observed staff being provided with this time. The division for critical care also had a full-time ICNARC auditor to monitor the quality and accuracy of data submission. Evidence from quality and safety meetings and discussions with senior staff suggest there had been issues in inputting ICNARC data in the past, however divisional leadership was now confident it accurately depicted patient outcomes.

Following inspection, the hospital provided the most recent ICNARC report from April 2018 to March 2019. Results showed that patient outcomes and mortality were within the expected ranges when compared to similar services. The Quality Dashboard for critical care wards at Queens Hospital showed eight of nine indicators were within normal range, with the remain indicator (Unit-acquired inflections in blood) slightly below average.

The critical care wards carried out an annual programme of audits to evaluate the quality of care being received by patients and overall performance. The results were reviewed in regular quality and safety meetings quality (both at ward level and divisional), and changes to service delivery were planned as necessary. The CCOT team also had a programme of audit, which in the last year had included audits on sepsis and deteriorating patients in theory caseload.

Performance was also viewed across a number of clinical development groups, aimed at improving the delivery of care and patient outcomes. For example, there was a monthly MDT deteriorating patients and sepsis group. This group organised teaching sessions for staff, reviewed relevant patient cases or incidents, and discussed possible service developments.

GITU/HDU were part of the first peer review rounds for the North East North Central London Adult Critical Care Network (NENCL). The review was carried out in 2018, and led by critical care experts from other network services. The services compared to each other locally through a North London critical care dashboard. The service also nominated staff from critical care to take part in divisional quality walks as peer reviews for other services.

Following inspection the trust provided evidence of the most recent peer review by the NENCL. The summary stated that critical care wards were “performing very well, and in our judgement met the majority of the Critical Care Standards that we reviewed them on. We found them to be well led and safe, very caring, responsive and effective.” The report stated that patients and relatives told us that
they could not find any fault with their care. The report also stated, “that they do have some concerns re the bed capacity issues” and identified areas for improvement.

**Competent staff**

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

From April 2018 to March 2019, 87.0% of staff within critical care department at the trust received an appraisal compared to a trust target of 90.0%. From April to June 2019, 25.4% of staff have received an appraisal.

The trust did not report any appraisal data for medical staff. We queried this with the trust and following inspection the trust reported that the appraisal rate was 60% for critical care medical staff.

**Queen’s Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>118</td>
<td>137</td>
<td>86.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>141</td>
<td>163</td>
<td>86.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust reported appraisal data for qualified nursing staff, that work across both sites, under a separate trust wide section.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>9</td>
<td>11</td>
<td>81.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

As of June 2019, the trust reported that 122 nursing staff had a post registration award in critical care nursing.

Site breakdown can be seen below:

<table>
<thead>
<tr>
<th>Site/Location/Unit</th>
<th>Total number of nursing staff in unit (qualified)</th>
<th>Total number of nursing staff with post registration award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital ITU/HDU/SKY A</td>
<td>87</td>
<td>63</td>
</tr>
<tr>
<td>Queen’s Hospital neuro ITU</td>
<td>50</td>
<td>28</td>
</tr>
<tr>
<td>King George’s Hospital ITU</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Critical care outreach team</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>
There were also 157 staff with training in specialised equipment.

Site breakdown can be seen below:

<table>
<thead>
<tr>
<th>Site/Location/Unit</th>
<th>Total number of staff (qualified and unqualified)</th>
<th>Total staff with up to date training in specialised unit equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital ITU/HDU/SKY A</td>
<td>100</td>
<td>82</td>
</tr>
<tr>
<td>Queen’s Hospital neuro ITU</td>
<td>54</td>
<td>39</td>
</tr>
<tr>
<td>King George’s Hospital ITU</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Critical care outreach team</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Critical care wards had a regular calendar of weekly and monthly meetings to monitor performance and staffing, as well as twice daily handovers.

The trust Quality Accounts for 2018/2019 identify that critical care wards were prioritised at Queens Hospital to work to the Getting It Right First Time (GIRFT) framework. GIRFT aims to improve the consistency of care to patients by reducing variation in practice. Senior staff we spoke with were positive about the impact of GIRFT on the wards.

Staff we spoke with were positive about the support and availability of the practice development nurses (PDN). PDN roles were split between have clinical and have practice, and provided advice and support to staff on training and revalidation. PDNs also delivered bespoke training to critical care staff as requested, or to support improvements to the delivery of care.

The PDN also supported new staff into their roles as part of local induction. New starters completed a one week trust induction (including mandatory training), followed by two competency assessments the following week, and would start full time in their fourth week. New starters received induction packs and national competency framework to complete in one year.

Agency staff received an induction checklist, orientation around the unit including equipment, covered key areas and the structure of the day. Agency nurses told us they received effective patient handovers and felt supported.

Any staff for the CCOT were required to have a post graduate qualification in intensive care, to be trained as practice assessors, and to have worked as a band 6 in a critical care environment. New starters were supernumery for one to three months (depending on experience). Some CCOT nurses were also supported in advanced nursing practice pathways at masters level.

The ITU met the Intensive Care Society standards for registered nurse workforce. This included ensuring a dedicated clinical nurse educator for critical care nursing staff, all newly appointed nursing staff receiving a period of supernumerary practice, and a minimum of 50% of nursing staff possessing a post registration award in critical care nursing.

Critical care wards had developed a pharmacy competency and training package to ensure all pharmacists working within critical care were working towards foundation and advanced pharmacy level practice. Critical care pharmacists were also undertaking the advanced assessment skills for training for non-medical prescribers.
The therapy manager held monthly therapies meetings which were attended by dieticians, physiotherapists and the Speech and Language Therapy (SALT) team.

**Multidisciplinary working**

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

The critical care provision included the input of consultants and junior doctors, nursing staff, and a range of AHPs including physiotherapy, occupational therapy, SALT, and dietician. At the time of the last inspection we identified that staff were no working together as an MDT. On this inspection staff stated they had good working relationship as a critical care team and across disciplines, and we observed this in effect on the wards. Staff stated they worked well together collaboratively, and this was supported by effective and approachable clinical leadership.

A weekly critical care governance meeting was run on Wednesdays for critical care staff across the trust. Managers made sure all staff were encouraged to attend team meetings, or had access to full notes when they could not attend. Critical care wards had a further regular calendar of weekly and monthly speciality meetings to monitor performance and staffing.

Staff held daily multidisciplinary meetings to discuss patients and arrangements for their care. While on inspection we attended the morning handover and found it to be well attended by medical and nursing staff (including the CCOT), and Allied Health Professionals (AHPs). Ward rounds also were held twice a day and attended by staff from all disciplines. Senior staff also stated that they had introduced weekly board rounds which was attended by the MDT. Staff stated this allowed them to proactively make discharge arrangements for specialist care if needed.

Critical care patients had access to multidisciplinary input to provide rehabilitative care as necessary. The critical care team worked with physiotherapists to meet rehabilitation needs in line with The National Institute for Health and Care Excellence (NICE) clinical guidance 83. On inspection we observed physiotherapists working with patients and discussing their care.

The last inspection included an area of improvement we told the trust they should consider: to include a dietician as part of the critical care team. There were now dedicated dieticians in post across all critical care wards. Staff were very positive about the support and advice the dieticians could provide. This complied with the FICM standard stating “critical care units must have access to dietitian five days a week during working hours”.

The CCOT completed weekly MDT reviews of medical ward patients with other therapies staff and provided education to staff on medical wards to manage critically unwell patients’ risk (such as sepsis and deteriorating patients. The team had also recently introduced a new initiative on critical care wards to improve identification and management of dementia patients.

**Seven-day services**

Critical care wards had dedicated pharmacy input Monday to Friday 9am to 5pm. On the weekends, pharmacy support was available 9am to 3pm on Saturday and 9am to 12pm on Sundays. Staff could access support from the on-call pharmacist and the site manager in the evenings and out of hours if needed.

Consultant and junior doctor cover was provided 24-hours, seven days a week. Critical care staff also provided an outreach service to monitor patients discharged from critical care to the ward.
The trust’s infection prevention and control (IPC) team was available Monday to Friday 9am to 5pm with access to the duty nurse for queries. For evenings and weekends, staff could access support from the on-call microbiologist.

The physiotherapy team worked Monday to Friday, 9am to 5pm, and there was an on-call physiotherapist available out of these hours.

The Critical Care Outreach Team (CCOT) provided support to patients across the hospital between 7:30am and 8pm seven days a week. Out of these hours there was support available from a CCOT registrar and consultant on until 11pm, and overnight from the clinical site managers.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

On inspection we saw leaflets that included advice on health promotion for all patients. This included advice on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness. Advice and guidance was also provided on clinical risks such as falls, pressure ulcers, and VTE.

Hospital staff provided advice to patients on managing their care after discharge. We observed staff from different disciplines advising patients on how to maintain their recovery after they had left the hospital. Staff also encouraged patients to contact the ward if they had any questions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>48</td>
</tr>
</tbody>
</table>

Medical staff in critical care at trust level did not meet the target for MCA/DoLS training. The trust did not report MCA/DoLS training completion rates for medical staff at site level. Medical staff work across both sites. Following inspection, the data provided by the trust showed that training in critical care was 84%.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April to June 2019 at Queen’s Hospital for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Qualified nursing staff in critical care at Queen’s Hospital met the target for MCA/DoLS training.

The trust reported compliance for MCA/DoLS training courses for qualified nursing staff, working across both sites, under a separate trust wide section. A breakdown of compliance for MCA/DoLS training from April to June 2019 for qualified nursing staff in critical care that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>11</td>
</tr>
</tbody>
</table>

Qualified nursing staff in critical care, working across both sites, all completed MCA/DoLS training. (Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had a policy in place for the management of patients under MCA and DoLS, and this was adhered to by Critical Care Staff.

Staff understanding of the MCA and DoLS was variable, and some staff were not sure about when the principles of capacity would apply. While staff stated if they were unsure they would ask the doctors, this meant that they may miss patients displaying signs that they had limited capacity to make decisions. All staff completed a mandatory training module regarding consent.

Doctors completed mental capacity assessments with patients whose capacity to make decisions was in question. Specific capacity assessments were completed when key decisions about the patients’ care were needed and best interests’ decisions were made when the patient was unable to consent.

Staff clearly recorded consent to treatment in the patients’ records as necessary. We saw examples of mental capacity assessments also completed in the patient records.

**Is the service caring?**

**Compassionate care**

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

During the inspection we saw most staff treating patients with dignity, kindness, compassion, courtesy, and respect. Most staff explained their roles to patients (including identifying themselves to patients who were not conscious) and put patients at ease during any interactions.

However, during the inspection we observed a few instances where staff did not identify themselves to patients or inform them about the care they were going to receive. In these cases staff were occasionally seen to talk over the patient, even if they were conscious, or not informing patients of their presence before delivering care.
We spoke with six patients in critical care during the inspection. Patients spoke positively about the care they received and how they were treated on critical care wards. Patients told us staff were respectful and provided them with space to ask questions about their care. Patients also stated that staff were professional and well informed about their treatment.

Critical care wards displayed on notice boards, and kept a folder of, thank you cards to staff from patients and relatives who had been on the unit. Comments in these cards included: “a huge thank you for your care”, “Thank you very much for all your support” and “my wholehearted appreciation for the care and professional attention”.

We saw that patient’s privacy and dignity was maintained whilst they were on the unit. Staff closed the curtains around the patient’s bed space before carrying out any personal care, and most staff communicate with the patient before delivering care. Physiotherapists ensured patients were covered up when moving and getting consent before touching the patient.

Critical care wards collected feedback from patients using the Friends and Family Test (FFT). The FFT asks people who use services whether they would recommend the services they have used, giving the opportunity to feed back on their experiences of care and treatment. The trust provided FTT data derived from the ‘I Want Great Care’ (IWGC) database. Data showed that for July 2019, the average number of patients who were likely to recommend the service was above 95%.

In the event of patient death, the service also collected feedback from family members. The questionnaire was sent 12 weeks after the bereavement and sought to identify ways to improve patient and family experience.

On critical care ward we saw “you said we did” boards. These boards identified feedback that had been received from service users, and changes that the wards had made based on this information.

### Emotional support

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

Most staff understood the impact that patients’ care, treatment and condition had on their wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the majority of interactions we observed.

Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care.

The unit used patient diaries which were funded by the hospital’s charity, and we saw examples of these on the wards. Patient diaries provided a daily record of each day’s event whilst a patient is in intensive care. Visitors (family members or friends) and staff were encouraged to fill in these diaries with information for the patients, so that they could be aware of things they may have missed. Supporting patients with a better understanding of what has happened to them in critical care may help to set realistic goals for recovery and minimise the risk of adverse long-term problems (National Institute of Clinical Excellence (2009) Rehabilitation after Critical Illness). Critical care wards did not have any diaries in use at the time of inspection as they had run out and were waiting for an order of new diaries to arrive.

Patients who were approaching the end of their life or required palliative care could be supported by the trust palliative care team if necessary. The palliative care team worked collaboratively with the critical care staff to manage end of life patients. Critical care wards had developed a 24-hour care
plan, with support from the palliative care team, to ensure the needs of end of life patients were well managed. Critical care staff had also occasionally in the past arranged for end of life patients to be transferred home (to their preferred place of dying) and there was a pathway in place to manage these arrangements. Staff were positive about the availability of support from the palliative care team, and arrangements for palliative patients.

The trust had developed bereavement leaflets for family members, which included information on available chaplaincy and religious support, advice and contact information for practical arrangements, as how to access support for dealing with a bereavement.

**Understanding and involvement of patients and those close to them**

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

We spoke with four family members of patients on the critical care ward. Family members were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans.

There was evidence of discussions of patient care with those close to them in the patient records. We also observed the needs of family members being discussed in the morning handover meeting by staff.

Critical care wards had access to two overnight stay rooms for family members of patients. Staff stated that these rooms were currently awaiting upgrade to include shower facilities and a pantry. The critical care wards also had access to two small meeting rooms where staff could meet with family members if needed.

There were information leaflets for family members for each critical care ward. These leaflets contained information on visiting times, lead staff, and hospital amenities.

Critical care staff had developed a number of opportunities for family members (both adults and children) to spend time with end of life patients and to commemorate their loved ones. The service provided palliative care boxes for families, which could include a handprint from the patient, a lock of their hair, and written messages. The ward staff supported children to write down their worries and put them into a “worry box” to help cope with the bereavement. Staff also facilitated family members to lie with their loved ones, if they wished, and staff stated that this was welcomed by family members.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

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

There were 22 general high dependency and intensive care beds (GHDU/GITU) at Queens Hospital, and a 12 bedded unit neuro-intensive care unit (NITU). GHDU/GITU and NITU were located on the ground floor, with a further ten bedded ward (Sky A) opened on the fourth floor since the last inspection.
Visiting times to the wards were advertised in public information leaflets, on the wards, and on the website. Staff stated that while there were dedicated visiting times, they could make exemptions for family members of patients that may need additional support or benefit from family contact. Critical care wards had access to two rooms where family members could stay overnight.

Critical care wards had access to two family rooms where they could discuss sensitive topics in a calmer environment. Staff stated that this was a useful resource to have. However, the public waiting room space for visitors of critical care patients was small and appeared very crowded on inspection. Staff were aware of this issue and recognised that it presented a risk but did not have an available nearby alternative room. Staff encouraged visitors to use waiting areas in the more public parts of the hospital, but this was not always accepted.

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the critical care wards. The trust website provided useful information about critical care wards, procedures that were provided, payment options, and the referral process.

There was a ‘Good to talk’ notice board at the entrance to critical care wards with information on the telephone translation service, raising communication needs for learning disability/hearing loss and visual impairment, chaplaincy (available 24 hrs per day) and Patients Advice Liaisons Service (PALS).

Staff were aware of how to access translation if patients or families were unable to communicate in English. Some staff stated they spoke other community languages so could offer some translation, however also stated that they would use interpreters where appropriate.

The hospital chaplaincy was available to meet the religious needs of the local population. The service had Christian, Muslim, and Jewish chaplains, and could also provide access to other local religious groups as needed. A duty chaplain was available on site seven days a week including evenings, and the service also offered a 24/7 on-call service. Staff that we spoke with were positive about the available support from the chaplaincy.

The Trust has a multi-Faith Prayer Room easily accessible and open 24 hours a day for all faiths. At the Queen’s site there was also a Christian Chapel, St. Luke’s. All three-prayer room had a range of religious texts for observances.

Staff stated they could contact security to support them if there were any threats of violence on the ward. Staff stated that the security team who were responsive to keep both staff and other patients safe.

Staff involved families and referred patients to Independent Mental Capacity Advocates (IMCA) if needed. IMCA is a role created by the Mental Capacity Act (2005) to support and represent the person in the decision-making process. We observed the IMCAs visiting the ward, and staff were aware of how to contact them as needed.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Visiting times for family and friends were Monday to Friday 10am to 12pm and 2pm to 9pm on weekends. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours.
Critical care wards met the needs of patients' dietary requirements. A choice of food was available at each mealtime to meet the patients' needs, including for any religious or spiritual requirements. Patients we spoke with were satisfied with the quality and choice of food on offer.

Critical care wards had access to a multi-disciplinary team of staff able to support the individual needs of the patients. Critical care wards had access to dedicated pharmacy, physiotherapy, and dietician input, and could refer to the therapies team for speech and language therapy, psychology and occupational therapy. Staff could also refer to specialist care teams such as the pain team or palliative care teams.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available for patients who were deaf or hearing impaired. Staff told us that patients with any communication difficulties would be provided with additional support, and we observed this on the wards.

The chaplains service was visible on the critical care wards and provided spiritual, religious, and emotional support to staff, patients, and families. Chaplains sat on the Palliative care MDT to support referrals, and anyone could be referred formally to the chaplaincy service for pastoral or religious care. Chaplains also undertake daily walkabouts throughout the wards. The chaplaincy service operated seven days a week and was available during evenings and weekends.

There were two available prayer rooms on the hospital site, one in the chapel and another multi faith space. Staff we spoke with stated there was established links with local religious leaders who could provide in reach if needed.

Patients that required social work support and discharge planning were referred by the nursing staff to the Joint Assessment and Discharge Team (JAD) service. The JAD team provided an integrated health and social care service, assessment, and discharge planning.

Support for mental health patients was provided by referral to the local mental health trust psychiatric liaison service. The Trust had a contract with this service and support/advice was available 24 hours per day.

Staff stated long term and stable patients could be supported to use the outdoor spaces near critical care. There was a garden space near the ground floor critical care wards that patients had access to use with their families if suitable. Staff also stated that patients could be moved to the fourth-floor critical care area if it would be beneficial to them, as this was a quieter space.

Critical care wards used an assessment pathway form for delirium and dementia. This included space to identify the individual needs and preferences of each patient, as well as a removal able form on delirium which provided information to family. The hospital also had dementia champions in the hospital who had received specific training, and staff stated they were a useful resource to provide support to dementia patients. Dementia patients were identifiable to staff by ID bands, so staff were aware if they may need additional support.

Although there was an assessment pathway for delirium and dementia, screening for dementia was inconsistently completed. On some critical care wards we found patients who had been identified as having dementia but an assessment had not been completed.

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**Access and flow**

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.
From June 2018 to April 2019, Barking, Havering and Redbridge University Hospitals NHS Trust had a similar adult bed occupancy level to the England average for 10 out of 12 months.

**Adult critical care Bed occupancy rates, Barking, Havering and Redbridge University Hospitals NHS Trust.**

The ITU wards were a mix of patients who had been referred directly to critical care, post-operative patients, and potentially patients from medical wards or outpatients with critical care needs. Neurology and neurosurgery patients were cared for on the Neuro ITU.

At the last inspection we identified that there were insufficient critical care beds available for the population served by the trust. Since the time of the last inspection, the opening of Sky A HDU ward on the fourth floor had increased the capacity of the critical care wards by ten beds. Staff recognised this had a significant impact in managing increased patient activity within this time frame, as activity had noticeably increased. Staff stated the HDU ward acted as a relatively lower acuity ward compared to GITU/HDU and NITU and could act as step down if a bed was needed on the ground floor critical care wards.

The Royal College of Anaesthetists recommends that the occupancy rate for critical care wards is kept below 70%. Senior staff stated that the occupancy rate was above the 70% recommended due to continually high activity at the hospital. Senior staff stated that while occupancy levels were high, patient safety was the top priority and occupancy was managed as much as possible to facilitate safe care and discharge.

Patient admissions and discharges were monitored throughout the day and through various meetings. A consultant-led morning handover meeting (attended by medical staff, nursing ward leads, and CCOT) discussed new referrals and admissions, as well as patients ready for discharge and their arrangements. Further admissions and discharges were discussed in hospital bed meetings with attendance from critical care wards’ staff.

Senior staff acknowledged that mixed sex breaches were a common occurrence on critical care wards. We saw that the service had reflected mixed sex breaches on the divisional risk register, and there were actions in place to minimise the risk of occurrence and mitigate any associated risk. Senior staff stated that mixed sex breaches were avoided as much as possible, managing acutely unwell patients was the priority.

Staff on critical care wards stated that while discharge planning was proactively managed, it could be difficult to find beds for critical care on medical wards. Staff stated that this was due to lack of
availability of beds but also for ward staff being able to manage critically unwell patients or with specific risks such as tracheostomies.

Managers and staff worked to make sure that they started discharge planning as early as possible. We reviewed patient records on the ward and found that discussions on discharge were proactive and included input from different disciplines.

CCOT nurses provided a follow up clinic for any patient who was discharged from critical care. Follow up clinics took place three months after discharge for any patient who was intubated for more than 48 hours, or who had been on a critical care for five days. Letters were sent out with an offer of an appointment and followed with a phone call. The follow up appointment was provided by a senior CCOT nurse as well as the CCOT consultant. Specialist input could be provided by other staff depending on the patient.

Staff we spoke with stated that while discharge planning for complex patients could be a challenge, the process for discharging patients had much improved since the last inspection. Staff suggested that this may be because of additional MDT input, improved pathways of care, and increased bed availability. Data provided by the trust at the time of inspection stated that 99% of patients are discharged from critical care within 24 hours of being declared fit, while 50% were discharged in four hours.

The CCOT supported medical wards between 7:30am and 8pm, 365 days a year. The service was due to move to 24 hours, however currently they were covered out of hours by CCOT reg and consultant on until 11, and then by the bed managers and anaesthetists overnight. Staff we spoke with were positive about the input available from the CCOT. CCOT reviewed any patient discharged from ITU within 24 hours. Each patient is then monitored and followed up with as needed until they leave the wards.

The CCOT offered patients a follow up clinic appointment after three months. All patients who were intubated for more than 48 hours, or have been on unit for five days, were invited. The follow up appointment would be completed by a CCOT nurse and consultant, with other staff invited as needed.

Following inspection, the trust provided information on the number of delayed discharges over four hours. Between April 2018 and March 2019. Between May and July 2019, monthly delayed discharges were between 38% and 47% on NITU and 51% and 60% on GITU.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

From April 2018 to March 2019 there were five complaints about critical care at Queen’s Hospital. The trust took an average of 37.6 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be answered within 25 days.

A breakdown of complaints by type is below:
<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient event</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>2</td>
<td>40.0%</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>1</td>
<td>20.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From May 2018 to April 2019 there was one compliment about critical care (at Queen’s Hospital).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff stated they would aim to resolve any patient complaints and concerns immediately. Staff were all aware of the complaints procedure and who had overall responsibility for managing the complaints process.

Any complaints about the wards were reviewed and investigated with input from senior leadership from the critical care wards. Staff were informed of outcomes from complaints investigations individually, in team meetings, and in quality updates. We saw critical care quality update posters on wards, which included information on recent complaints in critical care.

Leaflets on how to make a complaint and contact details for the Patients Advice Liaisons Service (PALS) were visible on all critical care wards. The complaints process included information about complaints process and how to contact the Parliamentary and Health Service Ombudsman (PHSO) if needed. Patients we spoke with were confident they would be supported to make a complaint if needed.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Critical care had a clear management structure in place. The critical care provision was part of the anaesthetics division and was lead by a divisional director of nursing, a clinical lead, and a divisional manager.

Staff we spoke with stated that the divisional leadership was visible on the wards and were approachable to staff. We observed critical care staff interacting well with the ward leadership during the inspection. Managers and senior staff of the ward appeared to be approachable.

Ward level nursing leadership was provided by the matron and senior sisters on each ward, who had responsibility for the day to day running of clinical areas. At the time of inspection, the matron had been in post for six months, and both ward and senior staff we spoke with were positive about the contribution she had made since her appointment.

Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management.
The nursing and medical leadership teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the ward.

Junior medical staff said they were well supported by their consultants and medical leadership on the critical care units. Consultants we spoke with were also positive about the support of their colleagues in critical care. The deputy clinical lead for critical care had recently been appointed to the lead clinical role, and staff were positive about the continuity of leadership this would provide.

**Vision and strategy**

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders, at the time of inspection.

At the time of inspection, the critical care service did not have a vision and strategy document care. Senior staff recognised that this was not in place and stated that it had been due to uncertainty about the develop of an overall clinical strategy within in the hospital, which would have significant implications for critical care. Senior staff were able to identify a number of business cases and development processes underway but recognised this was a work in progress.

Following inspection, the trust provided evidence of action plans specific to critical care vision, values, and strategy. This information covered developmental goals for critical care from up until 2021 and was assembled by the senior leadership team. Developmental and strategic goals for critical care included the acquisition and implementation of a clinical information system, more imbedded MDT involvement in handovers, a one-hour admission pathway to critical care, a 24-hour CCOT team, and developing a psychology service in line with GPICS standards.

Staff we spoke with were not aware of any specific vision for critical care wards and had not been consulted on a solidified strategy for the service. However, staff were aware of many of the service development business cases underway to improve the scope and delivery of critical care. Staff stated they were informed of these cases through team meetings and in communication from managers.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

At the time of the last inspection it was noted there were communication issues between different staff disciplines on critical are wards. On this inspection we found a much-improved relationship between doctors, nursing, and allied health professionals (AHP). Staff we very positive about their colleagues and we observed a collaborative working culture in place between the various disciplines.

Staff we spoke with told us that there was a no blame culture and they were encouraged to report incidents, and that they generally felt valued and respected by their colleague and divisional leaders. We found that a positive working culture was embedded in the unit, and this was encouraged by supportive and available leadership.

There was evidence of staff and teams working collaboratively to deliver good quality of care. We observed safety huddles and morning handovers during the inspection and found these to encourage contributions from all staff attending.
Staff demonstrated awareness of the trust values (PRIDE) and information on these values was displayed on the critical care wards. Critical care staff stated that the trust values were embedded well on their wards, and this was reflected in conversations with divisional leadership.

The trust provided occupational health services for staff. The team included occupational health doctors, specialist nurse practitioners, occupational health advisors, physiotherapists, psychologists and health and well-being advisors.

The trust had equality and diversity forums to consider the needs of all of their staff. This included the lesbian, gay, bisexual, and transgender (LGBT) awareness forum and a learning disability forum. The hospital had also implemented an action plan to meet the Workforce Race Equality Standard (WRES). The WRES examines an organisation’s commitment to equality, diversity, and inclusion across nine key indicators. However, we found that staff knowledge of these forums was variable.

**Governance**

The service systemically improved service quality and safeguarded high standards creating an environment for excellent clinical care to flourish.

There was a robust corporate governance framework in place which oversaw service delivery and quality of care. This included monthly speciality governance meetings across critical care, led by speciality leads and attended by ward staff, as well as hospital wide governance meetings. Oversight of governance for the service was managed by local leadership, with trust oversight provided by hospital wide Quality and Patient Safety team.

We saw records of the last four governance committee minutes and saw they discussed complaints, incidents, Key Performance Indicators (KPIs), training, subcommittees compliance, and any other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the team meetings. The meetings were minuted for dissemination to other staff who were not able to attend.

Critical care wards had a weekly governance meeting, co-ordinated by the quality and safety advisor, that was attended by staff from both trust hospitals. We attended this meeting and found there was discussion of ongoing risks on critical care wards, actions taken to mitigate risk, incidents, complaints, and any other quality issues. Staff stated they attended this meeting regularly and found it useful.

Critical care governance staff produced a quarterly Critical Care Quality Update and this was displayed publicly on all critical care wards. The update included incident trends, risks identified in clinical care, complaints, and upcoming dates for relevant training.

Staff we spoke with were generally aware of the risks and serious incidents that had occurred within critical care, as well as changes to service delivery that had occurred from incident investigations.

Senior leads told us morbidity and mortality meetings were incorporated into the weekly quality and safety meetings. We reviewed minutes from the last three quality and safety meetings and found the meetings were well attended by consultants from each critical care area.

**Management of risk, issues and performance**

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
Critical care wards had a local risk register which included risks relating to critical care. We reviewed this register and found consistent evidence of action plans put in place to control or eliminate the risks.

Senior staff stated the main risks for the division were identified as patient flow and occupancy, mixed sex accommodation, medical staffing, and resuscitation training. We reviewed the risk register and found this reflective of the main risks. Each risk on the risk register also had an action plan to limit any potential risks to patients, and these were reviewed regularly.

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

Although senior staff and leaders were aware of issues on the risk register, the risk register and governance processes did not reflect some of the risks we identified on inspection. This included the lack of introduction of Local Safety Standards for Invasive Procedures (LocSSIPs) to minimise risk of never events occurring, inconsistent hand hygiene practice, and the inconsistent use of the delirium and dementia pathway for some patients.

Critical care had systems in place to monitor performance, including incidents reporting, clinical governance meetings, patient feedback, audits and staff appraisals. Performance was compared locally across the hospital but also compared to similar critical care services in the London area. These systems highlighted areas of good practice as well as opportunities for learning.

Senior leads told us escalated items reported into the quality and governance steering group which was attended by the divisional director for nursing. The steering group would then report up to the quality and assurance committee (QAC) meetings which were chaired by the non-executive team.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security systems.

All staff demonstrated they could locate and access relevant information and patient records easily, which enabled them to carry out their roles.

The trust had introduced a quality assurance tool for completing audits of electronic records and evidencing compliance with standards and legislation. Data entry for the tool could be completed by staff using on their mobile and viewed by both ward staff and divisional leadership.

Information on policies, news relating to the service, and access to e-learning and trust guidelines, was available through the trust intranet. We observed that staff were able to navigate around the intranet and locate what information they needed.

**Engagement**

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

During the last inspection, the trust was advised that it should consider ways to engage patients in providing feedback specifically related to critical care services. On this inspection, we found
improvements had been made as the service used the trust’s ‘I want great care’ database to provide internal information on critical care services.

The hospital had a patient experience steering group which discussed feedback from patients and how to improve the patient journey, which included critical care. The trust patient experience strategy aimed to enable and empower all staff within the trust to feel able to put patient experience at the heart of everything they do.

Patient satisfaction was measured by a hospital survey of patients and their family members. Results from the patient satisfaction survey were discussed in local and hospital wide meetings.

Critical care staff held weekly team meetings and monthly quality and governance meetings. Staff were informed in these meetings about changes to service delivery, areas of shared learning, and any quality or safety issues. These meetings were minuted for those unable to attend. Staff we spoke with felt they were well informed about changes to the critical care wards.

The critical care service participated in the annual staff survey. Data shared on the inspection suggested that the division for critical care staff performed better than average in relation to the average response across the staff survey categories. Where response categories were worse than the trust average or were significant, senior leaders stated they used this information to inform engagement and communication with staff.

Ward managers had 1:1 meeting with the lead nurse and divisional director of nursing on Monday mornings. This provided time to evaluate the last week of work, share any learning and discuss the week ahead. In the afternoon every Monday the lead nurse meets with the band 7 staff and updates them on the relevant issues from the ward managers meeting.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Senior nursing staff on critical care wards were setting up development and innovation groups (DIGs) at the time of the inspection. Each DIG had an area of focus for quality improvement (eg diabetes care, renal care, nutrition) and membership for the groups were MDT. Each group aimed to identify areas for improvement in their DIG and make recommendations on how to service delivery could be improved.

Critical care had recently recruited two fully funded research nurses to support a research fellow in carrying out academic study and clinical improvement on the wards. This included National Institute of Health Research (NIHR) studies such as fluid management in emergency laparotomy patients, and project looking at cardiac arrests of patients in ITU. Critical Care was the first specialty in the trust to introduce these posts.

Critical care wards and staff had been the recipient of a number of awards since the time of the last inspection. Staff had been recognised by the Patient Experience National Network Awards in March 2018 for the use of patient diaries, as well as finalists in the Nursing Times Awards for the Emergency and Critical Care in October 2018.
End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

Macmillan specialists also support the trust and provide a palliative care team and the trust has an end of life care team (EOLC). Both teams work across both hospital sites across all settings. There are no inpatient palliative care beds.

There is a seven day a week face to face palliative care support for patients and staff and 24 hour telephone advice available from a consultant in palliative medicine. The trust use an individualised end of life care plan to tailor care in the last few days or hours of life. The trust also use the gold standards framework (GSF) to identify patients who may be in the last year of life. The GSF is in use in care of the elderly, renal, haematology, and oncology wards.

The trust reported they collect data to track progress against key strategic objectives and feedback from carers collected through the bereavement survey and complaints monitoring process. Data is feedback to frontline staff to improve care.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

End of life care was delivered on most wards at Queen’s Hospital, by ward staff who were supported by specialist multidisciplinary input. There is a specialist palliative care team (SPCT) and an end of life care team who provide care, advice and support in the delivery of direct patient care across the hospital.

In 2018/19 a total of 2214 patients died at both of the trust’s acute hospitals (Queen’s Hospital and King George’s Hospital). 1723 patients who were known to the specialist palliative care team died during 2018/19. Therefore 78% of deaths at the trust were seen by the specialist palliative care team. A total of 2082 patients were referred to the specialist palliative care team over the same period; 918 non-malignant disease, 995 malignant disease, 6091 face to face visits, 2440 episodes of telephone advice and 75 patients seen in outpatients.

The specialist palliative care team is comprised of palliative consultants, clinical nurse specialists, a social worker, discharge coordinator, team administrator and an occupational therapist. There were also end of life care facilitators and an end of life care consultant. They were supported by a team of chaplains and pastoral visitors. The role of the team includes assessment and care planning for patients with complex palliative care needs, treatment, medication, symptom control and emotional and psychological support for patients and their relatives and loved ones.

We spoke with a total of 11 patients and relatives. We also spoke with 37 members of staff, which included ward managers, nurses and healthcare assistants, ward doctors and specialist support staff such as occupational and physiotherapy staff. We also spoke with senior managers, porters, mortuary staff, chaplaincy, bereavement coordinators and all members of the specialist palliative care team, end of life care team and senior trust managers.
We observed care and treatment within the wards and reviewed 26 care records that included 21 Do Not Attempt Cardio-Pulmonary Resuscitation forms.

Is the service safe?

Mandatory training

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

The trust set a target of 90% for completion of mandatory training except for the information governance module which had a 95% target. Data was provided against the trust rather than at a specific site level.

A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling level 2</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Information governance</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health, safety and welfare</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non touch technique (ANTT)</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Equality, diversity and human rights</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90.0%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In end of life care the 90% and 95% target was met for all 11 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:
In end of life care the 90% and 95% target was met for four of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

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

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>12</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for both of safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>12</td>
</tr>
<tr>
<td>Training module name</td>
<td>April 2019 to June 2019</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>8</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for none of the two safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The specialist palliative care team (SPCT), end of life care team (EoLCT) and ward staff were able to demonstrate an awareness of safeguarding for adults and children. There was full awareness of who the safeguarding leads were in the trust and how they were contactable. The SPCT gave examples of incidents that would trigger safeguarding referrals.

Senior SPCT staff told us that safeguarding came up frequently in their work and the team had a close working relationship with the trust safeguarding team within the hospital. The team also referred to the community safeguarding team as necessary, which would usually follow ward visits where holistic assessments had taken place. Safeguarding issues were often discussed with families prior to referral.

All SPCT and EOLC team staff received safeguarding training as part of mandatory training which involved both e-learning and face to face.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All of the wards we visited were found to be clean and tidy. There were ample cleansing stations and we observed staff cleaning hands on entering and leaving the wards. We visited all areas of the hospital that provided end of life care to patients and their families. We found wards were visibly clean and hygienic. Cleaning schedules were in place and being followed.

The multi-faith rooms were visibly clean, tidy and well maintained.

The mortuary was clean and free from any odours. Fridges were visibly clean and cleaning schedules were in place. There were two cleaners who worked from 6am to midday. If there was a spillage outside of these times, there was a rapid response cleaning team who attended promptly. Porters were responsible for wiping down concealment trolleys after use with sporicidal wipes.

Environment and equipment

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

The trust used the McKinley T34 syringe drivers. Syringe drivers were kept by the palliative care team in their office. There was provision for access to the drivers out of hours which were kept on a
designated ward. There was also a stock of other equipment such as mouth swabs. The SPCT ensured that the syringe drivers were maintained by the medical electronic department. All batteries were single use and was a standard stock item on all wards. Wards were responsible for the cleaning of all syringe drivers before returning to the SPCT. Volunteers provided single use knitted bags for patients to keep syringe drivers in. For patients discharged home with syringe drivers, a paper trail was provided by the SPCT who also provided a padded postal bag to post the driver back. The SPCT stated that this process worked well but involved chasing the community teams to achieve return.

Syringe drivers were readily available when required. Five SPCT nurses all stated that in the last two years there had been no occasions when syringe drivers had not been available.

We were informed by therapy teams on wards there were no issues with access to equipment such as air mattresses and bariatric equipment for ward use. Wards reported good access to pressure relieving equipment overall. However, for patients who required pressure relieving boots there could be a delay of a couple of days, but staff were able to mitigate this by using alternatives such as pillows to relieve pressure.

The discharge facilitator from the end of life care team (EoLCT) organised equipment for end of life care patients returning home along with the occupational therapist. We were told that hospital beds for use at home were ordered by the district nursing teams who were employed by another trust. All other equipment relied on varying processes depending on which local authority patients were returning to. This was worked with by the discharge coordinator and occupational therapist having a good knowledge of each borough’s processes, good channels of communication and referrals being made as early as possible. However, even then, some district nursing teams were reported as not ordering a bed until discharge had been confirmed. The SPCT had a stock of equipment to assist with discharges such as slide sheets and commodes which were used in emergencies to assist in achieving rapid discharge. Any issues that related to access to equipment for the home were related to community partners and were difficult to mitigate beyond what was already in place.

In the mortuary, there were 68 standard refrigerator spaces of which eight were bariatric. There were 12 deepfreeze spaces, four of which were bariatric. There were also an additional nine fridge spaces which were below the line of the trolley and so not easy to access in terms of moving and handling.

In the last three years an average of 20 people per year were transferred out due to lack of fridge space. This was to a local funeral director under contract, with fridge spaces nearby.

The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority (HTA). HTA licensed establishments are required to meet HTA standards of consent, governance, traceability and premises, facilities and equipment. On HTA direction, people were transferred out of freezer spaces after 30 days in order to free up capacity. There was a contingency plan and contract in place with a local funeral director. So far this year there had been zero freezer transfers. There was a contract in place with a local funeral director for hospital funerals for adults and pre-term babies, transfers and storage. This was up for renewal and was currently in the procurement stage.

The most recent HTA mortuary inspection was in January 2018 which resulted in one major recommendation. This related to the temperature discrepancy between the internal fridge temperature and the temperature reading stated on the outside of the fridge, which had now been reduced to acceptable levels. There were also seven minor recommendations.

The mortuary was also the designated disaster mortuary of the Coroner for the Eastern Area of Greater London. This served the nearby five boroughs and was funded for emergency scenarios.
fridge spaces were held as a contingency for this purpose and were in addition to the standard 68 spaces.

An outsourced company managed the maintenance and state of the fridges which was linked to the private finance initiative (PFI) contract. Fridges were in blocks of 8s, 12s, 16 and 24 so any failure did not take out all capacity. The hospital was built in 2006 which was the same age as the fridges. However, the fridges were on the risk register as stated as ‘beyond repair’. The condition of the fridges went on the risk register in February 2019 due to five breakdowns over a one-month period. However, since this time attention had been paid to maintenance and repair and there had not been a break down since. The fridges were serviced at the end of July 2019. We were told by the director of nursing that there was now a mortuary fridge replacement programme that had been agreed with the outsourcing company.

Vehicular transportation in to and out of the mortuary was via a separate entrance straight in to the mortuary entrance on the lower ground floor and through secure entrance doors.

There was one viewing area for deceased patients which we were told was adequate for the number of viewings taking place. The area was currently being refurbished and redecorated so was not possible to assess its quality or suitability. There was a relatives’ entrance via the patient corridor for dignity and to avoid entering through the mortuary.

Personal protective equipment was used by the porters on the ward and in the mortuary and removed while transferring deceased people between the two. The porters’ route to the mortuary was through the ‘service core’ which meant they never travelled through patient areas with the concealment trolley once outside the ward.

There were two concealment trolleys for transportation of deceased patients to the mortuary and a specific box for infants. Trolleys had a shelf underneath to hold patient notes. Covers were adorned with the daisy symbol for dignity. Porters travelled to and from the ward via service halls and lifts in the service core of the building, which was inaccessible to patients and visitors.

Once in the mortuary, the hydraulic trolley and PAT slides were used to transfer the patient into a fridge. A label was placed on the front of fridge with patient name and ward and porters signed the fridge register before equipment was wiped down. An electronic system identifying fridge space allocation was due to go live next week. Post-mortuary, porters took the patient notes to the bereavement office during working hours. Out of hours, patient notes were taken to the security office and signed for.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

On Mandarin B, a 28 bedded haematology/oncology ward, a board round was held twice a day. The SPCT attended daily. We observed the board round where there was effective multidisciplinary team working. All representatives contributed and it was evident that their opinions were valued in assessing patient need and risk. The SPCT’s CNS provided support with symptom control to the oncology team. The oncology medical team also asked advice of the CNS. Patients were also referred to the SPCT during the board round and those with urgent needs were referred directly without the need to wait until the board round. We observed this happening when in the SPCT office, with staff happy to take referrals and respond to urgent referrals with promptness.
On the Mandarin B board round we observed, the oncology doctor indicated a patient might be suitable for discharge within the next 24 hours and the SPCT CNS who confirmed they would request a review from the palliative consultant prior to discharge to ensure that pain medication was optimised.

We observed a board round on Mandarin B where all team members used the gold standards framework (GSF) proactively, as prompts to initiate certain end of life care actions. The GSF used a rated system which indicated red for complex needs, unstable, need visiting daily, amber for more simple issue but need seeing regularly, green for awareness of but need less interaction and blue, to keep aware of discharges. All team members felt that the GSF was a positive thing that had helped promote good end of life care. We came across good examples of care where the GSF was in use. For instance, we observed that GSF amber had prompted the team to have conversations about prognosis and preferred place of care, treatment wishes and advance care planning with a patient. GSF had red prompted staff use of individualised end of life care plan and anticipatory medications.

We observed the SPCT and EoLC team’s daily handover. 46 patients were discussed including patients from both acute sites within the trust. All patients known to the SPCT were discussed daily. There was evidence of an effective triage system using the red, amber, green system. Red was for acute and were seen once or twice a day. Patients assessed as amber were seen daily or every other day and patients assessed as green were seen depending on need. There was also a blue category which stood for medically stable for discharge. All fast track patients for discharge were discussed as the SPCT facilitated all fast track discharge.

Although succinct, the handover meeting was highly effective. Patients identified to be requiring greater discussion were allocated for further discussion at the end of handover. We observed two examples of this. One patient with a syringe driver was experiencing a skin site reaction with the outcome for the lead nurse and two palliative doctors to discuss after the meeting in greater detail. The second example involved a risk of feeding for a patient who did not want artificial nutrition. The outcome was for the consultant to present the patient at the weekly palliative care/nutrition meeting. This group was set up to discuss complex palliative patient nutritional problems and jointly run by a nutrition consultant and palliative consultant. Senior SPCT staff told us they identified people at risk of deteriorating or dying by using guidelines from the gold standard framework. The SPCT responded to identified risk by attending patient review meetings around the hospital. For instance, doctors attended site specific multidisciplinary team meetings (MDTs) such as lung, upper GI, colorectal and haematology. CNSs from the SPCT attended a number of board rounds on a regular basis. There was an MDT meeting every Tuesday at 9am attended by all of the SPCT and EOLC team as well as the psychologist from the oncology service and the chaplain for discussion on red rated patients (complex needs unstable need visiting daily).

The individualised end of life care plan (IEOLC plan) allowed for the achievements of the five priorities for care. These included recognition of dying, sensitive communication, shared decision making, needs of families and a care plan that included food and drink, symptom control, psychological, social and spiritual care. We reviewed five IEOLC plans including three patients who had recently died. We found the plans had been completed to a high standard with both medical and nursing plans being complete. A review of the daily comfort rounds showed that patients were having assessments of essential needs that included assessment of pain, nutrition, hydration, mouthcare at least every two hours. Actions related to comfort rounds and additional care was recorded clearly in the daily additional information rounds. Medical notes for the two plans reviewed on the ward, showed that both patients had a medical review daily.

The end of life care facilitators reviewed all IEOLC plans including the quality and completeness of data, which was collated and sent to each ward. A recent initiative was that ward leads had to
respond with an action plan indicating how improvements could be made. Education and training were provided by the EoLC facilitators to help wards to achieve improvements in outcomes of action plans.

The enhanced supportive care team saw cancer patients who were receiving palliative treatment. The team held five clinics a week and had routine telephone clinics with patients.

**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>31.3</td>
<td>4%</td>
<td>0%</td>
<td>17.4%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12.0</td>
<td>0%</td>
<td>0%</td>
<td>21.0%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

There were six clinical nurse specialists (CNSs) in the SPCT plus a manager who all worked across the two acute hospital sites of the trust. The team also had a social worker, occupational therapist,
discharge facilitator and two administrators who were all full time. The end of life care team had three end of life facilitators who were all band 7 nurses who also worked across both hospital sites.

Both the SPCT and the end of life care team had increased in size and there was also an increase in administrative support. Senior SPCT staff told us they currently had no vacancies. However, there was a business case still ongoing to increase palliative care CNS by one extra full-time member to enable a CNS to be allocated to each hospital site at weekends. Currently there was one CNS working across both sites.

The enhanced supportive care team saw cancer patients who were receiving palliative treatment. This was a national initiative. The team comprised of one band 8B nurse, one CNS and one administrative support.

### Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

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<tr>
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<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>31.3</td>
<td>4%</td>
<td>0%</td>
<td>17.4%</td>
<td>203,077</td>
<td>220,366</td>
<td>72,883</td>
</tr>
<tr>
<td>Medical staff</td>
<td>7.3</td>
<td>11%</td>
<td>2%</td>
<td>3.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staffing rates within end of life services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The SPCT and end of life care medical team were made up of four consultants and one associate specialist, totalling 3.5 whole time equivalent working across both sites. There was palliative medical presence five days a week (Monday to Friday) at Queens Hospital.

Medical staff told us that in terms of what they would like to improve, there was a need to increase the size of the palliative medical team by at least one WTE. Additional medical resources would better support innovation and research which in turn would lead to ongoing improvement in care. Currently clinical care was given priority therefore innovation and research was slowed down, but not ignored.

The team were planning to advertise for two consultants in October 2019. It was reported that the local CCG had recognised the need for greater medical cover and were providing additional funding for one post in the community and one in hospital.
Records

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

In all ward areas we visited we found notes securely stored in locked notes trolleys, so confidentiality was observed. Other than notes in use with a team member we did not see any notes left unattended. All computer screens we observed that were unattended were blank/locked.

In the mortuary, a form came with the deceased patient from the ward with the porters. Mortuary staff received the body, but if they were not available, porters also undertook these duties. A register recorded all ins and outs in paper books; mortuary number, date deceased, age, sex, ward/dept, any risk of infection, post mortem, valuables and clothing, height, width, undertaker, signed by undertaker for release and date removed were all found to be recorded in entries. A long stay register recorded progress towards release. This was included in divisional quality reports.

Medicines

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

We saw four drug charts for patients who were recognised as dying. All were fully completed in terms of anticipatory medication prescribing. Medications were prescribed on each drug chart for pain, breathlessness, agitation, nausea and vomiting and respiratory secretions. Name of drug, dose, route and indication for use had all been recorded. This met the criteria for National Institute for Health and Care Excellence quality standard [QS144]; care of dying adults in the last days of life.

The EoLC facilitator reviewed all drug charts following patient death and despite a low criterion to fail, such as one omission on the whole chart equalled a fail, the current fully completed charts was more than 90%.

Drug charts we observed had been reviewed following a recognition of dying and medications rationalised with non-essential medications discontinued. This complied with national guidelines.

Wards reported good support from pharmacy who provided twice daily visits. We checked the availability of anticipatory medications on one ward and found all anticipatory medications were available. The ward sister told us that the drug supply was well maintained through the pharmacy. If a drug was not immediately available on the ward, the ward could obtain medication from other wards. However, the ward sister could not recall an incident when they could not give a drug because of unavailability.

We observed storage of medication on one ward. Drugs were double locked; locked cupboard in a locked room. Controlled drugs (CDs), were in an appropriate locked CD cabinet. All CDs were double checked (by two staff) and recorded in a designated CD book.

There were two advance nurse practitioner CNSs working in the SPCT. They were utilised for the provision of PRN medication particularly at the point of dying. The SPCT worked with medical staff on the wards to support the prescription of anticipatory medicines through telephone calls requesting advice. Guidelines for general medical staff were available on the intranet and were often printed off for doctors.
We were told there used to be an issue about anticipatory medicines due to lack of confidence in prescribing but the 24-hour on call palliative consultant cover had significantly improved this. The service received an average of a couple of calls a night.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2018 to July 2019, the trust reported no never events for end of life care.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

The trust’s electronic incident reporting system was used to break down information to deduce if an incident related to end of life care. This information was automatically shared with the SPCT lead who identified learning actions such as educational needs. We were given the example of a syringe driver incident at the beginning of the year which was investigated by a SPCT team member, audited and then audited three months later to measure improvement. The SPCT team leader and the head of quality and safety confirmed that there have been no incidents classified as either Never Events or Serious Incidents for end of life care in the year to date or last year.

We were told by senior SPCT staff that the team were aware of their role in relation to the Duty of Candour and that a culture of candour existed as the team were open and honest with patients and relatives. We were told the team would explain to patients and families and offer information around action plans resulting from incidents.

The trust’s patient safety summit occurred weekly and could be attended by anyone from the hospital. There was an SPCT presence at the summit every three months when a case was presented by them from an incident which was followed by discussion and reflection and any actions from the group taken forward to focus on learning.

The SPCT CNSs demonstrated good awareness of incident reporting using the trust’s electronic incident reporting system. One CNS gave us a recent example following taking immediate and appropriate action to correct a prescribing error that resulted in no harm to the patient. They also demonstrated awareness of the Duty of Candour through talking to the patient and next of kin. Learning was identified and shared. The staff member who initiated the error was given a period of additional support and supervision.

End of life metrics that were reported to the board quarterly and to the monthly clinical governance meetings included complaints and incidents. We saw a report for September 2019 that stated three incident reports. Two involved syringe drivers and one relating to medication. All three had been reviewed and an action plan had been formed to provide additional training for ward areas involved.
All mortuary incidents were reported through the trust’s electronic incident reporting system. We were given an example of an incident that occurred a month ago and of the investigation that followed. This demonstrated a clear process of reporting and investigation.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The individualised end of life care plan (IEOLC plan) was developed by the trust in 2015 and replaced the Liverpool Care Pathway. The IEOLC plan had been reviewed and updated since this time and the current version in use was version 5. We were told that through audit and review, significant improvement had been made to the care plan, with reduced content, improved layout to indicate responsibilities and more visibility of key aspects.

The IEOLC plan was evidence based and conformed to recommended best practice, being built around the five priorities for care as recommended by the Leadership Alliance for ‘Care of Dying People’, 2014. The IEOLC plan allowed for the achievements of the five priorities for care. These included recognition of dying, sensitive communication, shared decision making, needs of families and a care plan that included food and drink, symptom control, psychological, social and spiritual care.

We reviewed five IEOLC plans including three patients who had recently died and two active forms located on the wards. We found the plans had been completed to a high standard with both medical and nursing plans being complete. A review of the daily comfort rounds showed that patients were having assessments of essential needs that included assessment of pain, nutrition, hydration, mouthcare at least every two hours. Actions related to comfort rounds and additional care was recorded clearly in the daily additional information rounds. Medical notes for the two plans reviewed on the ward, showed that both patients had a medical review daily.

The end of life care facilitators reviewed all IEOLC plans. Their latest data showed that in July 2019, 60% of patients who died at the trust had an IEOLC plan. Ongoing support was provided by the facilitators to the wards to promote its use. The overall trend of its use was reported to be going up as a result of their work.

In addition to the number of IEOLC plans, the quality and completeness of data was also collated and sent to each ward. A recent initiative was that ward leads had to respond with an action plan indicating how improvements could be made. Education and training were provided by the EoLC facilitators to help wards to achieve improvements in outcomes of action plans.

The Gold Standards Framework (GSF) was being used on four wards with the plan to roll it out across the trust. Senior SPCT staff reported positive progress from early adopters. We observed good implementation of the GSF which was used positively to promote the needs of patients. Team members used the GSF proactively. All team members we spoke with told us that the GSF was a positive thing, that had helped prompt end of life care discussions and actions.

The hospital mortuary and post mortem facilities were regulated by the Human Tissue Authority (HTA). HTA licensed establishments are required to meet HTA standards of consent, governance,
traceability and premises, facilities and equipment. The most recent HTA mortuary inspection was in January 2018. The HTA found the named responsible individuals to be suitable in accordance with the requirements of the legislation. The HTA found one major shortfall relating to the temperature discrepancy between the internal fridge temperature and the temperature reading stated outside of the fridge which had now been reduced to acceptable levels. There were also seven minor recommendations that have now all been met.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

We were told there was a weekly complex nutritional MDT between the SPCT consultant, gastro consultant and SPCT CNS. The nutritional team also handled cases referred to them. Success was measured by patient comfort and patient and relatives were given evidence behind the decision to help with understanding. We were told this filled a gap following the Liverpool Care Pathway removal in to a more individualised approach.

The SPCT worked across the wards and alongside ward staff and doctors. They were visible and built relationships for the benefit of patients. We observed a board round discussion of a patient with poor nutrition as reluctant to eat. The ward sister initiated a plan to meet with relatives to discuss how to improve appetite, including suggesting the family bring in favourite foods, demonstrating holistic care in nutritional support.

In the SPCT handover meeting we observed discussion of a patient who did not want artificial nutrition. The outcome was for the consultant to present the patient at the weekly palliative care/nutrition meeting. This group was set up to discuss complex palliative patient nutritional problems and jointly run by a nutrition consultant and palliative consultant.

A review of the daily comfort rounds showed that patients were having assessments of essential needs that included assessment of nutrition, at least every two hours.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**

A review of the daily comfort rounds showed that patients were having assessments of essential needs that included assessment of pain, at least every two hours. On Mandarin B we observed a patient with pain being discussed with the SPCT CNS, informing them that the consultant from SPCT would follow up. There was good collaborative working between the SPCT and the pain team for the benefit of end of life care. There were joint visits taking place such as between a pain team nurse and one of the palliative consultants. We were told that the two teams sometimes shared patients and it was common for the pain team to ask for help, especially with acute pain. It was also common for the SPCT to transfer patients to the pain team for things such as chronic pain. There was a combined palliative and pain team multidisciplinary team meeting (MDT) fortnightly to discuss patients with complex pain needs.

Senior SPCT staff told us the SPCT worked with the hospital pain team in a number of ways. There was a lead for the acute pain team and both were aware of each other’s services as patients were
sometimes seen by both. The pain team usually referred to the SPCT. Joint visits involving CNSs from each team occurred for handovers or where there were complex or difficult cases of pain in order to provide different perspectives. The SPCT had a meeting with the pain anaesthetist fortnightly and the SPCT would handover to the pain team for specific reasons such as for surgery.

**Patient outcomes**

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

The enhanced supportive care team saw cancer patients who were receiving palliative treatment. This was a national initiative where patients were referred at the point of diagnosis. Referrals came through data collection and were exclusive to patients with the five tumour groups with worst patient outcomes that covered lung, upper Gi, cancer unknown primary, metastatic prostate, breast. The goals of the enhanced supportive care team were to reduce the 30-day mortality rates post-chemotherapy and engage in challenging conversations with patients about the quality of life. An annual report was sent to NHS England for national comparison. Aims were to reduce crisis admissions of those in palliative care. The project had achieved the slowest growth rate of emergency admissions.

The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in One Chance To Get It Right and NICE Guideline (NG31) and Quality Standards (QS13 and QS144). The outcomes from 2018/19 for Queens Hospital were as follows:

- Recognising the possibility of imminent death  9.1 (national average) /9.4 (hospital average)
- Communication with the dying person - 6.9 / 7.8
- Communication with families and others - 6.6 / 6.5
- Involvement in decision making – 8.4 / 8.2
- Governance - 9.5 / 10
- Workforce/specialist palliative care 7.6 / 10

Individual plan of care - 7.4 / 6.6 While scoring higher on most pointers for individual plan of care, documented assessments of nutrition and hydration between recognition and time of death were lower. However, the hospital scored higher than average for the management of pain and symptom control, receiving fluid and nutrition. The hospital also scored highly when asked if staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life, and that staff at the hospital made a plan for the person's care which took account of his/her individual requirements and wishes.

Needs of families and others 6.1 / 4.4 The needs of families/others asked about the care and support provided to families/others at the time of and immediately after death: emotional/psychological needs, spiritual/religious needs, cultural needs, social needs and practical needs. While scoring above the national average on most points, the service scored less well on access to counselling and psychological services.
Competent staff

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

From April 2019 to June 2019, 92.6% of staff within end of life care at the trust received an appraisal compared to a trust target of 90%.

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<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
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(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Appraisal rates for SPCT and EoLC staff, mortuary services staff, bereavement officers and pastoral care staff were given as 100% for the last two years.

All new staff received EoLC education on induction. The chaplaincy were also involved in nursing and healthcare assistant induction and corporate induction. End of life care facilitators were instrumental in delivering increased and improved end of life care education across the trust. End of life care was now part of the ‘essential training’ for all clinical staff. Following this success, we were told there was now a need to also establish training for non-clinical staff.

The end of life care team (EoLC team) team did essential training for ward staff to enable better identification of patients who were deteriorating or dying. There was a focus on teaching of ward staff that included prognostic indicating framework from the Gold Standards Framework. Staff received training on GSF. End of life care facilitators supported training on the wards and provided ward based learning that included one to one training for new staff if needed.

Senior SPCT staff told us the successful transition from care plan to individualised end of life care plan happened due to what had been taught to staff. Ward MDT discussion involved SPCT and EoLC team staff giving advice and they were also asked for their input when visiting wards.

Two of the SPCT CNSs were accredited trainers for advanced communications and two of the palliative doctors ran communication sessions for senior medical staff. Communication workshops were run quarterly and were available to all. The SPCT also held bespoke communication workshops on request and SPCT staff were involved in running a series of workshops relating to communication including advanced communications. We were told that oncology and elderly care wards made regular requests.

Regarding end of life training for doctors, we were told that all foundation programme doctors received a session on palliative and end of life care as part of their routine training. Additional training was provided to relevant specialty teams as needs are identified based either on our end of
life care metrics or complaints. Specific communication skills training was available for all staff including doctors and bespoke sessions are arranged for whole departments on request.

Regarding the education and development of SPCT and EoLC team members, we were told there was opportunity for education, with needs identified through appraisal and interim appraisal. One CNS was undertaking a masters in end of life care, another was undertaking the advance nurse practitioner’s qualification. Other opportunities that arose were offered to the team by their line manager. For instance, there were offers of study days by a local hospice and the CNSs felt these were allocated fairly.

There was a weekly teaching session for one hour for the SPCT and EoLC team. All members of the both teams were included, including the social worker, occupational therapist and discharge coordinator. Team members contributed to the teaching rota, but it also included speakers from other areas of the hospital and from external speakers. We were given examples of recent speakers.

The SPCT were currently in the process of developing essential training for all doctors, encompassing both e learning and face to face sessions to cover appropriate NICE guidance and relevant training curricula.

The lead chaplain contributed to the teaching of a post graduate course on chaplaincy at another hospital and took placements on within the trust.

The SPCT were involved in the training of staff for syringe driver use and had undertaken initiatives to improve access to syringe driver training that had included an instructional video and operational guidelines on the palliative care page of the trust intranet. Staff using syringe drivers were expected to have undertaken training and passed a competency process to use them but in practice it was not possible to identify how many trained nurses had obtained competency and there was no comprehensive list of who had received the training.

The end of life care champions programme had recently been relaunched, clarifying the role and expectations, making it a more effective role which had been redefined with support from the SPCT and EoLC facilitators. There was a relaunch in September 2019. Training days had taken place with clearer expectations which included the roles supporting audits, implementing end of life care standards and being a resource for their own teams.

Care after death training was considered important for best practice for all nurses and healthcare assistants. This was a two-part training module that included a mortuary visit for familiarity with mortuary processes and how the mortuary was managed and run. This also included how to talk to relatives. This was initiated following instances observed by mortuary staff relating to adequate preparation of bodies by ward staff and a need for better communication between the wards and the mortuary. Modules were devised by the mortuary lead and the training commenced in July 2018. Currently 90% of all hospital nurses and healthcare assistants had completed the e-learning module and 50% had completed the mortuary visit. We were told that ward staff visiting the mortuary had proved a positive way of allaying apprehensions about care after death and although there was more to do, having achieved 50% of staff visiting the mortuary was considered positive progress and on course to meet the three year target of 90% compliance.

The mortuary manager offered weekly training for porters on a Wednesday. They explained the process from the ward to the undertaker step by step and covered different types of scenarios that included respectful behaviour around families, issues with the shrouding of the body and the capacity of fridges out of hours.

Porters told us the training focussed on the task being different to other portering tasks and emphasised dignity and respect of relatives and the deceased. 75% of porters had received the
training. The aim was 100%, but due to natural staff turnover this was a challenge which had been made easier by the regularity of training sessions.

Porters told us they felt respected and appreciated by both mortuary staff and ward staff in part due to being included in training delivered by the mortuary staff. Porters were confident in challenging ward staff regarding the appropriate shrouding of deceased patients and were confident to raise any concerns although we were told that neither needs to happen since care after death training had begun for nursing and healthcare assistant staff.

**Multidisciplinary working**

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

We encountered positive working relationships between the SPCT and specialist teams to meet specific patient needs such as nutrition and pain. There were good relationships with different departments and teams around the hospital that had been built up by both the EOLC team and SPCT. This included with traditionally difficult to reach groups such as haematology and critical care. We encountered both SPCT and EoLC team members engaging with ward staff in positive ways that included care of patients and education. The SPCT were core members of multiple weekly multidisciplinary team meetings (MDTs) around the hospital. This included multiple oncology MDTs, haematology MDT, complex nutrition MDT, critical care MDT and motor neurone MDT every two weeks. The team also attended numerous board rounds on wards. Ward managers told us they were well supported by the SPCT seven days a week and by the EOLC facilitators.

The EoLC team met monthly with the community teams from each of the three boroughs within the trust’s catchment area. There was a Barking, Havering and Redbridge end of life steering group which brought together community teams for the three boroughs of the trust community, which was the first step towards integrated care for end of life care between the community and the trust. A joint EoLC strategy had been compiled together following the teams agreeing to work towards providing an integrated service. There was now one DNACPR across hospital and community.

We were told there was regular contact with GPs through telephone calls with SPCT members for specific reasons such as for discharge. There was a Macmillan GP liaison officer who coordinated communication within the trust.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Currently each member of the SPCT worked one weekend in six. We were told that service success had meant that the weekend workload had increased and was now similar to that of a weekday. Regarding weekend cover, senior SPCT staff told us that one CNS covered both sites which was a challenge that had been placed on the risk register. We were told that the leadership of the cancer and clinical support directorate were working to address this. Administrative support had begun working at weekends last year to reduce the need for CNSs to spend time on admin, thus freeing up their time with patients at weekends. We were told that moving towards integrated care had meant that the CCG had acknowledged this and will address it following the addition of consultants.
Trust and hospice palliative consultants covered a 24-hour on call advice line. There were six in total and follow up was offered at weekends to relieve pressure on the CNSs. The service received on average a couple of calls a night.

At weekends all viewings of deceased patients were carried out by the mortuary team who were on call for this purpose. We were told this worked out as each appropriate person being on call every four weeks. During out of hours and in emergencies, the on-call mortuary staff were accessed as necessary by the site manager. An example of this was given as when fridges were nearing capacity.

Health promotion

Staff gave patients and their relatives practical support.

Relatives were encouraged to contribute to giving care to their loved ones by ward staff and the SPCT. Senior SPCT staff told us relatives were shown how to provide mouthcare and assist with feeding where this was appropriate to do so. We were told this was promoted among relatives because it had a therapeutic and calming effect on patients and helped their wellbeing.

Relatives told us there had been good communication with all staff and told us they had all the information they needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:

| Training module name | April to June 2019 | | | | |
|----------------------|-------------------|---|---|---|
|                      | Staff trained     | Eligible staff | Completion rate | Trust target | Met |
| Mental capacity act and deprivation of liberty safeguards | 13 | 13 | 100.0% | 90.0% | Yes |

In end of life care the target was met for the one MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:

| Training module name | April to June 2019 | | | | |
|----------------------|-------------------|---|---|---|
|                      | Staff trained     | Eligible staff | Completion rate | Trust target | Met |
| Mental capacity act and deprivation of liberty safeguards | 8 | 9 | 88.9% | 90.0% | No |
In end of life care the target was not met for MCA/DOLS training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The combined SPCT of six nurses were able to demonstrate a good understanding of the mental capacity act. We also spoke with staff on wards who were all aware of the process for mental capacity. We saw eight completed Mental Capacity Act (MCA) assessments that had been fully completed, signed and dated.

As with the MCA, both SPCT and ward staff were able to demonstrate a good awareness of the Deprivation of Liberty Safeguards (DoLS). On the ward, we saw eight DoLS assessments that were all fully completed, signed and dated. We also found ward staff we spoke with knowledgeable about DoLS. On one ward, we found there were two ‘cohort bays’ for confused patients where deprivation of liberty safeguards were in place. Cohort bays were staffed 24/7 with the bay never being unstaffed in order to ensure patient safety.

We were told by a sister on a medical ward that MCA and DoLS were both included in ‘essential training’.

The EoLC facilitator carried out continuous review of all do not attempt cardio pulmonary resuscitation (DNACPR) forms for patients who had died. We reviewed 21 DNACPR forms that were in place at the time of our visit. We found that all 21 of the forms could be found immediately at the front of the notes. All 21 of the forms stated the name and designation of the person completing the form and had been signed by them. All of the forms had been dated when signed and 20 out of 21 (95%) clearly identified the rationale for the decision. 20 out of 21 (95%) of the forms indicated that the patient, their relative or next of kin had been involved in the discussion and 95% had been signed by the consultant.

We found that DNACPR forms had been completed to a good standard and countersigned appropriately by the consultant within 24 hours. There was good documentation of patient and family discussion. Forms did not include trigger questions relating to capacity, but we observed good practice and discussion of capacity.

Is the service caring?

Compassionate care

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

We visited nine wards and found that ward staff were polite, friendly and professional. We spoke with a total of 11 patients and relatives who all told us that staff were caring in their attitudes towards them. One patient we spoke with told us that the caring and kind attitudes of staff had made a difference to the ward being a good place to be. Another patient stated that the nurses and the doctors were very kind and caring and could not do enough to help them. We spoke to two relatives of one patient who told us that staff showed compassion in the way they cared for their loved one and that care on the ward was very good. They also told us that symptom control had been prompt for which they were very grateful.
We spoke to another two relatives of a patient. We were told that there had been good communication and the family felt that their loved one was being treated with kindness and by caring staff. We were also told that there had been good support from the SPCT, who they had built a good relationship with.

Care after death had been promoted in the hospital since July 2018, when the mortuary lead began training for nursing and healthcare assistant staff. This promoted a culture of the care and dignity of the deceased. Porters told us that since this training had been introduced, instances regarding ward staff’s appropriate shrouding of deceased patients had greatly improved. Porters training around mortuary processes and the transfer of deceased patients to the mortuary emphasised the care and dignity of the deceased patient and sensitivity towards relatives.

Bereavement office staff demonstrated that a caring and compassionate approach to their work was at the centre of what they did. It was explained that they too used the hospital and had experienced bereavement of loved ones. This had contributed to their approach to working with families. As a result of this there were many aspects to how they engaged with relatives which were based on understanding of the need to be caring.

The bereavement office sent a condolence card to the family of the deceased. A bereavement survey was sent out 12 weeks after. Survey results formed part of the divisional monthly metrics and were shared with divisional leads to disseminate to the appropriate health care professionals and form part of the divisional action plan that is submitted to the end of life care operational group.

The survey asked the following questions: Did the healthcare team explain your relative/friends condition and/or treatment in a way that was easy to understand? How would you rate the way in which hospital staff treated any discomfort (for example pain or agitation) your relative/ friend experienced? How would you rate the emotional/psychological support you and your relative/friend received from hospital staff? (e.g. doctors, nurses, chaplains, physio’s, OT’s, porters, domestics etc.) How would you rate the dignity and respect you and your relative/friend received in the very last days of their illness? (washing, dressing, toileting and shaving)? How would you rate the place and way in which you were told that your relative/ friend was dying? How would you rate the way in which the hospital worked together with your relative/ friend’s GP and other services outside the hospital? How would you rate the support you received from the bereavement office when you collected the medical cause of death certificate? Were your relative/friends belonging handed to you in a white bag with a flower logo? Were you given a ‘Because We Care’ booklet? Were you given a card when you collected the medical certificate from the bereavement office with the divisional nurses’ contact details?

Trust wide, the response rate for the bereavement survey for 2018 to 2019 was 26.2%. The bereavement survey results were positive, with all question responses rated in the 84-96% as either good or satisfactory. The survey results formed part of the divisional monthly metrics and were shared with divisional leads to disseminate to the appropriate staff. Action logs were attached to each question, demonstrating progress with each.

**Emotional support**

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

The chaplaincy were involved in supporting dying patients and their loved ones. 80% of their referrals were from the SPCT and EoLC teams. They also attended a lot of ward rounds where they picked up a proportion of their work by engaging with patients and relatives. We were also told they
spent time getting alongside staff and management. They attended oncology MDTs for both children and adults, the patient experience committee and the equality and diversity committee. Other meetings were shared among chaplaincy colleagues such as organ donation.

The chaplaincy made the distinction between spiritual and pastoral work and the significance of providing both services to people based on need and choice. We were told that most of their work was providing emotional support to people who needed someone to talk to. The chaplaincy team visited most wards and had volunteers to carry out pastoral work. There were 40 volunteers across both of the trust’s hospitals although a majority of this work was carried out at Queen’s Hospital.

There was a full time Christian and Baptist chaplain for the trust and a Muslim chaplain one day a week. We were told that this was based on the locality’s demography where 8% of staff and 9% of patients were Muslim. In addition to this, there were two more imams and a Sikh and Hindu chaplain on the bank staff team. There was also a part time Jewish chaplain, who worked half a day a week.

The chaplaincy engaged in a number of other activities that promoted emotional support for patients, relatives and staff. They carried out end of life prayers and contract funerals for baby loss and for adults with no next of kin. This was a negotiation between the trust and the local authority. We were told that if a child died, which averaged as three or four per year, the chaplaincy conducted debriefs. They also ran a reflection group on Mandarin B for staff where there was a lot of care of the dying. The chaplaincy also carried out training with the emergency department, the SPCT and EoLC facilitators on spiritual aspects on the care of the dying. In terms of developing the service, there was a plan to bring in a specific bereavement chaplain. The chaplaincy service won the patient experience national network award 2018.

An initiative started by the chaplaincy was ‘mourning coffee’, in partnership with Macmillan and the SPCT. There was one in each of the three boroughs the trust worked with and each occurred monthly in the community, for people who had been affected by bereavement in the trust’s hospitals. This had proved to be a well-attended and successful support group for emotional support and linking people in to other community resources such as community health services to GPs and other counselling services. Themes such as power of attorney, coping with death, grandparent’s role and family had been covered in the mourning coffee groups.

The daisy logo was used throughout the hospital to indicate priority for the care of the dying. This was placed on the door of rooms so people were aware of dying patients. The EoLC team launched the daisy branding as it met a need that everyone accepted as being important. A flower was used due to most wards being named after flowers, which made it more appropriate way of communicating patient need in this area. The idea was taken on board with porter teams and now covers on concealment trolleys had the daisy symbol on them. Porters were aware of the daisy symbol and its meaning around the hospital. Porter staff were invited to talk to the mortuary manager for informal pastoral chats following any traumatic incidents.

Emotional support was part of the holistic assessment carried out by the SPCT. The social worker was also around to provide emotional support and the team also referred to the pastoral team. Carers needs were identified during holistic assessments and the SPCT were able signpost people onto services if required. The weekly MDT meeting for end of life care was attended by all SPCT and EoLC team members, the chaplain for discussion on complex patients, and the psychologist from the oncology service, who had input with oncology patients. They also provided mindfulness sessions for the team.

‘Be kind to yourself’ hug course was a Macmillan nurses initiative in place at the hospital. There were eight facilitators for this who worked trust wide and was for cancer survivorship. The course ran for six weeks every Friday afternoon and was a wellbeing group. There was also a parallel course for
patients’ families. The scheme had been in place for 18 months and was for patients from all trust
Catchment area and surrounding areas of West Essex and Brentwood.

Outcomes from the 2018/19 National Audit of Care at the End of Life (NACEL) showed the hospital
Scored 4.4 against a national average of 6.1 against the needs of families and others. The needs of
Families and others asked about the care and support provided to families/others at the time of and
Immediately after death: emotional/psychological needs, spiritual/religious needs, cultural needs,
Social needs and practical needs. While scoring above the national average on most points, the
Service scored less well on access to counselling and psychological services.

Counselling services for non cancer patients was described by key staff as an unmet need trust
Wide.

Understanding and involvement of patients and those close to them

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

We spoke with two relatives of one patient. We were told that there had been good communication
And the family felt they had all the information they needed. There was unlimited visiting hours which
Had made it easy for the family, who said they had received good support from the SPCT, who they
Had built up a relationship with and who involved them with all aspects of the care.

Another relative told us “we were really kept up to date by doctors and included in things”. We were
told the “nurses were very good, continually assessing my (relative’s) symptoms and asking if they
Were in any pain”. “The palliative care team have been very good as well, yesterday (allocated CNS)
Was away but her colleague came to see us and knew everything about the situation. It was really
good. We have not had any problems”. The relative of the family then stated, “there is nothing to
Improve”.

Family members of one patient told us the only thing they could find that was not great, was that on
The day of admission on the elder’s admission ward, there seemed to be some confusion where
different doctors kept coming to assess and all kept asking the same questions over again.
However, this all changed when the patient was transferred to Sunrise ward where communication
Was reported as excellent from the doctors who took their time to explain and were very caring. We
Were told that they also asked if the family wanted to talk in a side room or go somewhere else for
Further privacy.

The Gold Standards Framework included thinking ahead and about what was important. On
Mandarin B board round, we observed a discussion of a patient who had been referred to the SPCT
Early in the diagnostic pathway due to poorly managed symptoms. The rationale for this was
Explained to the patient and family who were reassured so the patient and family were not under the
Impression that the patient was actively dying.

Both a patient and their partner we spoke with told us they were very happy with the care received.
They felt included and involved in decisions and told us that communication with all staff had been
good and they had all the information they needed.

Communication with patients and carers was evidenced in care records we saw, which we found
documented in the patient records on a regular basis.
Is the service responsive?

Service delivery to meet the needs of local people

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

Dennis’s Den was a private space for patients and their families to use. The service identified a need for a space where patients could be with their families that was away from the ward space but accessible for patients unable to get out of bed. The room was bright and inviting, with comfortable furnishings and play areas for the children of patients and relatives. There were a range of resources to support families help their children understand what was happening to their loved one and where needed, to try and prepare children for the loss of a parent. Resources were available for families to create shared memories and capture them using memory boxes. There was a ‘worry tree’ where children could write down their worries and hang them on the tree to help them deal with some of their anxieties. There was a range of resources that were suitable for children of different ages. Dennis’s Den was a resource for the hospital. It had been used for a wedding, for patients from ITU and their family, family celebrations and for just having time together.

There were concessions available to the families of dying patients including unrestricted visiting, reduced cost parking, drinks provided and often also food. Sofa beds had been purchased by the SPCT and were available to wards for relatives to sleep overnight. On one care of the elderly ward, the sister stated that they always tried to find comfortable seating for relatives who stayed for long periods, including recliner chairs. Wards always tried to find side rooms for dying patients unless the relatives or patient advised otherwise. This priority was balanced against other patient needs such as infection control.

We observed a number of leaflets available for patients and relatives on aspects of end of life care including Proactive EnhAnced CarE (PEACE), (the plan was designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP), thinking ahead (advance care planning) and the end of life care plan, all available to patients and all available in alternative formats or languages through PALS.

Reminiscence Interactive Therapy Activities (RITA) screen was available to support patients. RITA was a touchscreen computer on a stand used for dementia patients with personalised photographs/videos and period programmes and music. A bid was put in for two; one at each of the trust’s hospital sites. Money for one was raised through fundraising and one through a charity. This was hoped to be a potential way to do advance care planning. Funds were also raised through dying matters, which attracted local businesses to support initiatives.

There were two multifaith spaces at the hospital. Both were located centrally, above the main foyer area and were well used. The first was mostly used by Muslim patients, relatives and staff, with a male / female divide. We observed this space to be a calm and clean. Saint Luke’s Chapel was a multifaith space used by patients, relatives and staff. The chaplain held a midday prayer service from Monday to Friday. Staff memorials also took place and the room was also used a lot as a quiet space. We were told the chaplaincy service would like to develop a counselling service, but space was described as limited. A quiet space was available in the PALS rooms, but the hospital was described as generally short of space where someone can go and sit.

The bereavement office and chaplaincy had combined to relocate to a patient and relative accessible location within the hospital. The bereavement office had previously been in a restricted access area.
so was now open to the public. This included a registrar who worked in the hospital three days a week. This had been named The Daisy Centre and was now a one stop centre. It was also a finalist for nursing times awards 2018.

The daisy was the symbol for everything to do with end of life care within the trust. The logo appeared on leaflets, it was placed on patient doors or by the bed, on concealment trolleys, on property bags. This was so it was discreetly and respectfully known by staff that to show extra sensitivity with out making it over obvious. This was good for staff as it demonstrated patient focus and compassion.

The process of transporting a deceased patient began when two porters were allocated to a task and went to the mortuary to collect concealment trolley. The trolley was safety checked before use. An orange bag for patient notes was placed on the bottom shelf. Porters travelled to the ward via service halls and lifts in the service core of the building which was inaccessible to patients and visitors. Patients were already shrouded by nurses and we were told this was generally done to a high standard. We were also told that porters were confident in understanding the patient need to be shrouded and were confident in challenging this if it was incorrect. They were also knowledgeable about the need for the correct paperwork to accompany the patient. The deceased patient was transferred to the concealment trolley and ward staff spoke to patients’ relatives during the process. Porters were mindful of the need for dignity and of other patients during this process.

We observed key ward staff wearing armbands with their name and designation clearly identifiable.

All relevant end of life care documents were held in the blue box with daisy motif on all wards. It included information for patients, relatives and staff. It included screening tools, assessments, patient and carer information and leaflets around end of life care.

### Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

We encountered positive working relationships between the SPCT and specialist teams to meet individual patient need. The SPCT and EoLC teams engaged with ward staff in a number of ways that included the individual needs of patients and ward staff need for training and education in matters relating to end of life care. This meant that everyone took responsibility for providing good end of life care.

The SPCT had built good relationships with different departments around the hospital including traditionally difficult groups such as haematology and ITU. The teams attended numerous board rounds and multidisciplinary team meetings. Ward managers told us they were well supported by the SPCT and by the EoLC facilitators. They also linked in to the community teams and a joint EoLC strategy had been compiled to work towards providing an integrated service to increase the flow of information and integrate roles to meet patient need. There was regular contact with GPs through telephone calls with SPCT members for specific reasons such as for discharge. There was a Macmillan GP liaison officer who coordinated communication within the trust. The electronic discharge summary included a trigger for information on GSF, communication with the GP regarding thinking ahead conversations, fast track and end of life care.

The SPCT were part of the dementia strategy group. One SPCT staff member had completed a master’s degree on advance care planning for people with dementia. We were told that research so
far suggested that advance care planning could work better, and the team were consulting patients and families on approaches that may work best for them. On a board round we observed, a discussion took place of a patient who required an advance care plan discussion, but the patient was currently confused. A decision was made to delay this with the expectation that this would improve. The discussion included recognition of needing to involve family, which demonstrated a patient focussed approach.

There was a mental health liaison service within the trust and who worked collaboratively with the SPCT. Their relationship was described as good and involved undertaking joint visits. We were also told the SPCT got quick advice by phone when required and the service was available seven days a week.

There was a trust lead for learning disabilities who the SPCT worked with closely to accommodate any patient needs. Both ward staff and SPCT staff made them aware of any patient need. This was described as a responsive service that offered good support including through joint visits and support to discuss complex issues. The lead also liaised with the community end of life care teams.

Regarding access to interpreters, we were told the interpreter system was always used for first assessment and was accessed through the intranet. If there was an urgent need such as if someone was imminently dying, then digital translation could be used in an emergency. A member of the discharge team spoke four languages and was also often utilised.

The enhanced supportive care team saw cancer patients who were receiving palliative treatment. The enhanced supportive care team held five clinics a week and had routine telephone clinics with patients. They proactively phoned patients when they were not heard from. Patients were usually handed over to community services post treatment, but this decision was made case by case. The services tried to link patients in to clinics to coincide with other appointments such as chemotherapy, in order to reduce the need for patients to travel into hospital. All chemotherapy was delivered at Queen’s Hospital. The enhanced supportive care team had received national recognition. It was shortlisted for a Nursing Times Award 2018 in the cancer care category and was a finalist in the HSJ Palliative Care Award 2018. For shared learning the project had been presented at a trust senior leader meeting. Externally it had been presented nationally and at consultant MDT’s, including at the Christie NHS Foundation Trust, leading experts in cancer care, research and education, where enhanced supportive care was first conceived.

All viewings of deceased patients in the mortuary were carried out by the mortuary team who were on call at weekends for this purpose. We were told this worked out as being on call every four weeks.

**Access and flow**

**Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.**

The SPCT led on complex and fast track discharges which had reduced the length of time to get patients home. The discharge co-ordinator was part of the SPCT, facilitating fast track discharges and hospice bed requests. Their role was to see and assess patients for suitability and liaise with ward teams and the SPCT nurses.

Rapid discharge was audited for quality improvement. In July, August and September 2019 there were 159 referrals for fast track discharge with an average length of stay from decision to discharge...
of four days. Referrals were usually seen on the same day and always for urgent referrals. Their role included speaking to the patient and family to discuss their preferred place of care and understand the challenges to this, especially when patient deterioration was rapid. They also liaised with care homes, community teams and the local CCG. A good relationship was reported with the CCG, who usually made a same day decision on funding.

Delays to discharge were monitored. We were told the most common challenges were the availability of suitable nursing home beds, the availability of hospice beds and authorisation and access to hospital beds and mattresses for patients going home. Discharge was also supported by the ward teams and the social worker in the SPCT. Patients for discharge were discussed at the SPCT’s daily handover and MDT meetings. We were told that wards that had introduced the GSF were more efficient in managing end of life care discharges. We were told that over the last two years there had been a big positive change in end of life care in the trust and the engagement with hospices, care homes and district nurses had also improved.

The discharge facilitator from the end of life care team (EoLC team) organised equipment for end of life care patients returning home along with the therapist. We were told that hospital beds were ordered by the district nursing teams but all other equipment relied on varying processes depending on which London borough patients were returning to. This challenge was met by the discharge coordinator and therapists having a good knowledge of each borough’s processes, good channels of communication and referrals being made as early as possible. However, some district nursing teams were reported as not ordering a bed until discharge had been confirmed. The SPCT had a stock of equipment to assist with discharges such as slide sheets and commodes which were used in emergencies to assist in achieving rapid discharge. Any issues that related to access to equipment for the home, were related to community partners and were difficult to mitigate beyond what was already in place.

The Pro active EnhAnced CarE (Peace) plan was designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP. Five peace plans were reviewed on Sunrise A and Sunrise B and were completed to a good standard. We found these were detailed and personal to each patient. Some patients with Peace plans had been readmitted. Where this had happened there had been a review of the care plan that identified actions and improvement. Plans had been reviewed in team meetings with end of life care facilitators. There had been improvements to the instructions and so they had learnt from this to produce clearer plans.

The service was transitioning to Coordinate My Care from the PEACE Plan, which was used for people going home as well as those going to a nursing home. 82% of people with the document died in their desired place of care. Information was currently duplicated on CMC but the service did not want to lose the paper-based system yet in case of gaps while people transitioned over.

Three members of the SPCT had become ‘trusted assessors’ for local nursing homes. This was an initiative that had been put in place to resolve delays to discharges to nursing homes due to delays in the homes carrying out assessments for admission. These relationships had been built up by visiting the homes and liaising with key people regarding what assessments were required and who could be trusted to carry them out. There was a now a standardised two page admission assessment for admission that had the agreement of the homes, who had authorised SPCT ‘trusted assessors’ to complete on their behalf. This had reduced delays in discharges where wards used to wait for the homes to come assess patients as suitable. Provided data shows a reduction in discharge time from 7 / 8 days to 48 hours. This concept had been presented nationally and was now modelled for the continuing healthcare initiative.
There were monthly meetings between the SPCT lead and district nursing leads from each borough that discussed the transfer of care from hospital to community services. There was a referral system in place and cross boundary medication charts were now used in the community. The service was also looking to create an electronic district nursing form for authorisation for syringe driver use. A pilot had been completed and the process was due to begin a the week after our visit.

A palliative outpatients’ service was provided the hospital. The service offered was flexible to meet patient need, with at least one appointment per clinic left open for urgent access or for someone attending the hospital for another appointment such as for investigation, so as to prevent the need to make another journey.

The electronic discharge summary sent to GPs and had a section for end of life care initiatives that included GSF. When the GSF was selected there was a drop-down box which could be used to identify the GSF stage, which gave the GP an indication of prognosis and indicating patients were either in their last days/ weeks, months or a year or less of life. The end of life section also allowed the transfer of information including DNACPR status, an advance care planning tool called ‘thinking ahead’, an advance decision tool to refuse treatment and the PEACE document.

There were currently four wards that had accreditation for the Gold Standards Framework (GSF). The aim was to roll this out across the whole trust. GSF at the hospital was currently a paper process that created some barriers to the sharing of information with community partners. Information contained within the GSF was shared with community partners and within the trust in the following ways. Within the trust, GSF information was uploaded on to digital platforms so that information could be seen by all staff including the emergency department. For patients registered on co-ordinate my care (CMC) outcomes were uploaded on to this database for external partners to access when required. GSF information was also shared with community partners including GPs, out of hours services, ambulances and hospices via confidential nhs.net email accounts. Paper copies were sent to care homes that did not have nhs.net accounts.

SPCT referrals were accepted from any clinical area or disease site. Recent data showed a 50/50 split between malignant and non-malignant referrals. The SPCT were able to respond to requests for advice and support quickly. 90% were seen within 24 hours and 100% within 48 hours. There was an average of ten referrals a day, with an average of six known in time for the daily morning meeting when they were allocated. Later referrals could result in reallocation due to prioritisation. Emergency department referrals were prioritised.

The enhanced supportive care team’s patients were referred at the point of diagnosis. There was no mention of palliative or end of life in the team’s name as they were designated to work with patients from the earliest possible stage. They proactively looked for potential patient need. Referrals came through data collection and were exclusive to patients with the five tumour groups with worst patient outcomes that covered lung, upper GI, cancer unknown primary, metastatic prostate, breast. Referrals were identified by the administrator. The team could see patients on an ad hoc basis in line with need. This could be the same day through prioritisation. The service was now seeing 194 patients and had received 717 referrals since the project commenced.

In 2018/19 a total of 2082 patients were referred to the SPCT; 918 non-malignant disease, 995 malignant disease, 6091 face to face visits, 2440 episodes of telephone advice and 75 patients seen in outpatients.

A total of 2214 patients died at the trust (across both sites) in 2018/19. 1723 patients were known to the SPCT died during 2018/19. Therefore 78% of deaths at BHRUT (across both sites) were seen by the SPCT.
237 patients were discharged to their own home with a peace plan. 173 patients (73%) died outside of hospital. 34 patients (14%) died in hospital. 30 patients (13%) remained in the community.

The individualised end of life care plan audit showed that between April and August 2019 that out of 134 eligible deaths, the care plan had been used 60% of the time. Results could be broken down by ward and area for providing support on completion.

Every allocation of work was recorded by the porter management with the names of the porters, in case of any queries. Porters had a 30-minute response KPI for deceased patients. This was escalated to the porter manager if unallocated at 25 minutes.

Learning from complaints and concerns

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

From April 2018 to March 2019 the trust received one complaint in relation to end of life care at the trust (0.1% of total complaints received by the trust). The trust took 37.0 days to investigate and close this complaint. This was not in line with their complaints policy, which states complaints should be completed with 25 working days. The subject of this complaint was around the care to a patient.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints and compliments relating to end of life care were identified or learned from through discussion across all governance groups. End of life care issues were also identified by analysis of complaints. The SPCT’s clinical lead was cited on complaints relating medical staff and end of life care, which were then fed into the EoLC meeting. We were told this tended to be around communication and consultants were invited on to advanced communication courses to address any learning. Sometimes the SPCT took part in round table meetings with families to identify what happened.

End of life metrics that were reported to the board quarterly and to the monthly clinical governance meetings included complaints and incidents. We saw the report for September 2019 that stated three incident reports and no complaints.
Is the service well-led?

Leadership

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

The chief nurse was the executive lead for end of life care. We were told this had enabled the SPCT lead to have access to more key people and progress end of life care services. The chief nurse was also the chair of the end of life steering group and there were now strategic and operational end of life steering groups, both with divisional representation and patient partners.

There was a SPCT lead nurse and lead clinician and a separate end of life clinical lead based in the hospital and community on a rotational basis. The trust lead clinician job plan for their role was described as formalised and fixed. It was signed off at the last committee for end of life care.

There was a lead chaplain who coordinated and led chaplain services for the trust and worked closely with the bereavement office. They also sat on the UK Board of Healthcare Chaplains (UKBHC). This became accredited by the professional standards authority two years ago. The chaplain also chaired the Essex and East London Network of Chaplains. Both helped to link the chaplaincy in to the bigger picture for chaplaincy services locally and nationally. There were also training events for pastoral visitors every year through this network.

The mortuary lead had been in post for two years. They had raised the profile of the work of the mortuary services and the care and dignity of deceased patients. This included membership of group meetings and organising training for nursing staff and for porters.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The end of life care strategy for 2016 to 2021 identified achieving six priorities of care which were aligned to Care of the Dying in the Last Days of Life (NICE 2015), and Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020 (the National Palliative and EoLC Partnership). The strategy was updated to reflect updated guidance and presented to the board in May 2019.

It identified personalised care planning, shared records, comprehensive and robust data, involving, supporting and caring for those important to the dying person, education and training, 24/7 access, working with local patient experience groups and individuals with personal experience and leadership as key components to meet the six ambitions of care which were: 1. Each person is seen as an individual, 2. Each person gets fair access to care, 3. Maximising comfort and wellbeing, 4. Care is coordinated, 5. All staff are prepared to care, 6. Each community is prepared to help.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
Morale was evidently very high throughout the SPCT, EoLC team and the enhanced supportive care team. This was also the case for the chaplaincy service and bereavement service. These were all seen as rewarding roles for the staff involved, which combined delivering high quality and effective services with the excitement of new projects.

All teams contributing to end of life care at the hospital were effective in delivering high quality services. Wards were well supported to deliver good quality end of life care to patients, which was supported by senior leaders, specialist teams and mortuary staff. Everyone knew their roles and were keen to fulfil them without exception including porters. End of life care was seen as everyone’s responsibility at the hospital.

When Sunrise A, an elderly care ward were GSF accredited it was celebrated and acknowledged by the executive team who visited the ward to congratulate them. Two of the team attended a conference to receive the accreditation award.

**Governance**

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

The SPCT were integral members of the end of life committee, which helped identify and initiate end of life improvements in the trust. The chief nurse was the chair of the end of life steering group, which had boosted the profile of end of life care within the trust which was now joined up with community services. There were now strategic and operational end of life steering groups. Both had divisional representation and patient partners.

The EoLC team met monthly with the community teams from each of the three boroughs within the trust’s catchment area. There was a Barking Havering and Redbridge end of life steering group which brought together the community teams for the three boroughs, which was the first step towards integrated care for end of life care between the community and the trust. A joint EoLC strategy had been compiled together following the teams agreeing to work towards providing an integrated service providing: increased flow of information and working, and a future plan to integrate roles. There was now one DNACPR form across the trust and community.

Mortuary services came under the trust division of cancer and clinical support. This arrangement had been in place for the last six months and was previously came under the management of pathology. It was reported that this arrangement enabled greater assurance and accountability which was supported by the new divisional lead. Monthly mortuary reports went to the divisional meetings for cancer and clinical support. We were told that the SPCT and EoLC team had a good relationship with the mortuary manager, who linked into the EoLC committee and contributed ideas to the action plan. They were responsible for setting up training for nurses and HCA staff that included a mortuary visit including the viewing room, mortuary processes and changing practice to improve the way people were laid out.

The chaplaincy came under the trust division of patient experience. This arrangement had been in place since 2015.
Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The ‘Improving end of life action plan 2019-2020’, was based on the priorities of NICE Supportive/Palliative Care guidance and National End of Life Care Strategy to ensure that the trust had a clear direction. Ongoing progress was highlighted against each agreed action. This was aligned to the end of life care strategy. It was reviewed at the specialist medicine directorate clinical governance meeting (monthly) and at the end of life care committee (quarterly). It was reported up to the quality and safety committee and the trust board. Monthly metrics were produced at a trust wide level, divisional level and ward level. All reports went to the end of life committee. Action plans had been introduced five months ago and sat with divisional nurses and discussed at monthly meetings. It was felt there was good ownership and engagement across different divisions. There was also a process of escalation to the chief nurse, the executive lead for end of life care, if needed.

There were monthly audits of all deaths completed by EoLC facilitators to identify patients for the individualised end of life care plan and areas of the care plan that had not been completed. Results were displayed on notice boards and discussed at team and board meetings.

In addition to this the end of life care committee reported to the trust board every quarter with an updated action plan and on improvements that have been made. Each month EoLC metrics were produced to monitor progress of the implementation of the Individualised end of life care plan, all tools used for advance care planning including the Gold Standard Framework and feedback from the bereavement survey which were fed back to the divisions for action. A new task and finish EoLC group had been started to look at divisional metrics and develop action plans to feed into the end of life care committee quarterly meetings.

End of life care committee minutes showed attendance from key staff such as chaplaincy, palliative consultants and SPCT team members. It also demonstrated attendance from divisional matrons, service leads from the trust and senior representation from key partners such as the community hospice. Action logs, end of life metrics, audits, progress with GSF were among regular agenda items. The end of life task and finish group met monthly with representation from trust divisions to report on progress and challenges with priorities for end of life care and end of life metrics.

Information management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust predominantly used paper-based records. Both paper and electronic systems were updated by the SPCT to ensure the information was readily available, duplicating the work effort. There was an alert on the ward electronic patient information system and the electronic record system in use in ED to indicate if patients were on GSF or at the end of life. The alerts were added by the EoLC facilitators to both systems. The alert contained detail, where appropriate, of DNACPR status, the presence of advance care plans and preferred place of care and or death. The EoLC facilitators worked with ED to support the most appropriate care pathway for end of life patients.

The trust had recently signed up to Coordinate My Care, an electronic palliative care co-ordination system. This was currently in pilot phase on three wards. Expectation was that once coordinate my
care had been fully rolled out it would replace the PEACE plan. Coordinate My Care was used in the trust and all teams in the community with end of life care responsibilities such as ambulances, GPs and care homes. GPs were now being incentivised to increase its use. This was now being filled out across the trust and community so that all end of life services could talk together. This included the use of one DNACPR form and communicating preferred place of care.

**Engagement**

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

Patient experience meetings occurred on a monthly basis. They were attended by chaplains, matrons, the SPCT and ex patients who were now involved in the hospital and known as patient partners, who liaised and visited wards with patients and relatives. The SPCT presented and shared ideas and materials with the group. The EoLC committee also had two patient relatives as members. Through bereavement surveys, patients were involved in initiatives through patient stories including teaching and operational meetings. For instance, this was used for Dennis’s Den after receiving permission from patients and relatives to share their story.

Age UK volunteers had advanced care plan discussions and help patients complete ‘thinking ahead’ documents both in the hospital and at home. This was shortlisted at the Patient Experience Network National Awards (PENNA) 2018 as care navigators and recognised as a potential national initiative. The pilot started in a GP practice using Age UK as care navigators to put information on to coordinate my care. There were now two new volunteers who had been recruited to move this further forward.

There were quarterly meetings with the heart failure team and local hospice. This was introduced as a difficult to reach group. The hospital referred in to pick up patients unknown to the service.

Renal clinic meetings took place twice a month to discuss advance care plans. We were told this had proved very popular. A generic advance care plan clinic was being launched across the trust and in community bases for patients to be referred into.

An all borough (Barking, Havering and Redbridge) conference on end of life care took place in March 2019 at King George’s Hospital. This was a cross network conference organised by the trust to take a systems wide approach to end of life services, covering aspects of end of life care including community providers, nursing homes, local authorities, hospices and MacMillan. A&E attendance was covered, and a patient spoke about their experience of services. District nurses, GPs and consultants shared quality improvements around advance care planning and someone from the GSF also spoke.

**Learning, continuous improvement and innovation**

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

There were numerous initiatives, methods of learning and innovation in the palliative and end of life care services at every level of care within the trust. Some had been recognised nationally and some had been nominated for awards from national and leading organisations. These have been referred
to throughout the report. For instance, a red bag scheme had been adopted by the trust. This was a bag containing information and the property of patients who were admitted from nursing homes, which was then sent back to the home if the patient died in hospital.

A recent patient focussed innovation included multi professional collaboration to provide an advance care planning (ACP) clinic for renal patients. This was nurse led and shared between renal CNSs, SPCT CNSs and the EoLC facilitators. Clinic slots were for one and a half to two hours so as to provide enough time for patients. Relatives were also encouraged to attend.

King George Hospital

Evidence appendix
Barley Lane
Ilford
Essex, IG3 8YB

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

The trust had two emergency departments at King George Hospital and Queen’s Hospital.

The emergency department (ED) at King George’s hospital was open 24 hours a day, seven days a week. It saw 63,636 adult and 18,775 children patients between October 2018 and September 2019 with serious and life-threatening emergencies, as well as treated patients with minor injuries. The hospital did not take trauma or child patients arriving by ambulance. The hospital had a resuscitation room able to receive adult and paediatric patients who need immediate medical attention. The emergency urgent care centre (EUCC) at King George Hospital treated minor illnesses; this service was delivered by another provider and was open 24 hours a day, seven days a week. This service was not part of the inspection. It was inspected in March 2019 and was rated good.

The department had different areas where patients were treated depending on their needs, including a three-bed resuscitation area, a 16 cubicle majors area, ‘Fit2Sit’ area (introduced in hospitals to stop patients lying down on trolleys if they were well enough to sit up), six ‘sub-acute’ (minors) cubicles for patients with less serious injuries and ailments and a six-bed clinical observation unit. A separate paediatric ED had its own waiting area.

Total number of urgent and emergency care attendances at Barking, Havering and Redbridge University Hospitals NHS Trust compared to all acute trusts in England, March 2018 to February 2019
From March 2018 to February 2019 there were 225,065 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2018/19 compared to 2017/18. In 2017/18, the proportion was higher than the England average and in 2018/19 the proportion was the same.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2018 to February 2019
Discharged includes: no follow-up needed and follow-up treatment by GP
Referred includes: to A&E clinic, fracture clinic, other OP, other professional
Left department includes: left before treatment or having refused treatment
(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to permanent nursing and medical staff and made sure they completed it.

Nursing and medical staff received and kept up-to-date with their mandatory training. The trust set a target of 90% for completion of all mandatory training courses apart from information governance which has a target of 95%.

A breakdown of compliance for mandatory training courses from April 2019 to June 2019 for qualified nursing staff in the emergency department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>48</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>48</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>48</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>48</td>
</tr>
<tr>
<td>Sepsis (paediatric) e-learning</td>
<td>48</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>48</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>48</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>47</td>
</tr>
<tr>
<td>Fire safety</td>
<td>47</td>
</tr>
<tr>
<td>Resuscitation level 3 - adult immediate life support</td>
<td>34</td>
</tr>
<tr>
<td>Information governance</td>
<td>46</td>
</tr>
<tr>
<td>Resuscitation level 2 - paediatric basic life support</td>
<td>44</td>
</tr>
</tbody>
</table>

King George Hospital emergency department met the target for all 12 mandatory training modules for which qualified nursing staff were eligible. At the time of the inspection the completion rates for mandatory training reminded high and above trust target with most training completion rates scoring 98% or above.

A breakdown of compliance for mandatory training courses from April to June 2019 for qualified nursing staff in emergency department that worked across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
</tbody>
</table>

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At trust wide the emergency department, met the target for eight of the 12 mandatory training modules for which qualified nursing staff were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust did not report mandatory training completion rates for medical staff at site level. Medical staff worked across both sites. The trust reported completion rates for medical staff only at trust level. A breakdown of compliance for mandatory training courses from April 2019 to June 2019 at trust level for medical staff in urgent care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>81</td>
<td>83</td>
<td>97.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>81</td>
<td>83</td>
<td>97.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>79</td>
<td>83</td>
<td>95.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>78</td>
<td>83</td>
<td>94.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>76</td>
<td>83</td>
<td>91.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>66</td>
<td>73</td>
<td>90.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sepsis (paediatric) e-learning</td>
<td>44</td>
<td>49</td>
<td>89.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>64</td>
<td>73</td>
<td>87.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>64</td>
<td>73</td>
<td>87.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation level 2 - paediatric basic life support</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>65</td>
<td>83</td>
<td>78.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The mandatory training was comprehensive and met the needs of patients and staff. Three months before a training module was about to expire staff received a notification. A practice development nurse (PND) monitored nursing staff compliance with the mandatory training completion and alerted staff when they needed to update their training.
As at the previous inspection, in the paediatric ED there was always a nurse with paediatric intermediate life support (PILS) training. All nurses had basic paediatric life support (BPLS) and all band 6 nurses had PILS training. In addition, there was always a doctor with advanced paediatric life support (APLS) as required by the national standards for children and young people in emergency care settings.

Between April and June 2019 emergency department met the target for six, of the twelve, mandatory training modules for which medical staff were eligible. Training completion rates at the time of the inspection were even lower, with only one out of twelve modules meeting the trust target. However, the trust explained that the October month was generally when their training was at its lowest due to doctors’ rotations in September and October. Roughly around 20-25 staff out of 108 whole time equivalent (WTE) were new to the trust at that point. The trust was in the process of either updating their training on the system or booking them onto the necessary courses or e-learning module. All new employees had allocated time in their rotas to complete mandatory modules and were regularly reminded to update their training. Staff who were non-compliant were not permitted to work bank shifts.

At this inspection we did not receive assurance that locum doctors completed all mandatory training. The trust had mandatory training completion figures for 31 out of 64 doctors. There was no evidence that locum doctors had advanced life support (ALS), advanced trauma life support (ATLS), paediatric life support (PLS) or sepsis training. Of the 31 locum doctors all but one had up to date basic life support, safeguarding level 3 training, infection control and blood transfusion; all but two had up to date moving and handling training; all but three had up to date information governance training. The training modules that were up for renewal were expired for no longer than 2 weeks at the time of the inspection.

**Safeguarding**

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

The department had very clear safeguarding processes and staff showed good awareness of how to report an abuse. Staff had good understanding of safeguarding and could define triggers that would prompt further enquiries and/or a referral. They were aware of their role in protecting vulnerable patients. Patients attendance was viewed as an opportunity for staff to safeguard them from harm and offer support.

Staff received training specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training. All staff received safeguarding children level 3 and safeguarding adults level 2 training as the minimum. As at the previous two inspections, there was a high compliance level for nurses with safeguarding training in both adults and children modules. We also saw an improvement in compliance levels for medical staff with three out of four training modules meeting the trust target.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 for qualified nursing staff in the emergency department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
King George Hospital emergency department met the target for all the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 for qualified nursing staff in urgent care that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults’ level 3</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>47</td>
<td>48</td>
<td>97.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff across the trust wide emergency department met the target for three of the four safeguarding training modules for which they were eligible. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 at trust level for medical staff in urgent care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults’ level 4</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>69</td>
<td>72</td>
<td>95.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>47</td>
<td>58</td>
<td>81.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At trust level the emergency department met the target for all but one safeguarding training modules for which medical staff were eligible.

Staff had good knowledge and understanding of safeguarding and their role in protecting vulnerable patients. The service carried out several initiatives to raise staff awareness and knowledge of safeguarding. In addition to the mandatory modules, nursing staff had an inhouse safeguarding training during ‘keep in touch’ (KIT) days. The training included different topics, for example: domestic violence, awareness of patients’ mental health needs, talk from a psychiatric liaison team about pathways, child sexual exploitation, female genital mutilation, body image, eating disorders, and knife crime amongst others. Any learning points from safeguarding cases were discussed at the daily handover. Once a week staff were invited to attend a simulation session where real case scenarios were presented and some of the case studies were related to safeguarding. Staff learned about safeguarding through a monthly safeguarding bulletin which included information on any
relevant changes to safeguarding processes, review of and learning from safeguarding cases (children and adults), different types of safeguarding (fabricated illness, parental mental ill health), and any other important messages.

The ED used a safeguarding flagging system so that staff could quickly identify previous safeguarding issues, looked after children (child is being 'looked after' by the local authority when the local authority arranges for the child to live somewhere other than at home) and children in need (‘children in need’ are children that need local authority’s involvement to achieve or maintain a reasonable standard of health or development).

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. The trust adopted a “think family” approach when assessing the needs of patients. The approach promoted co-ordinated planning and delivery of care to child, adult, and their wider family group. Staff knew how to make a safeguarding referral and who to contact if they had concerns. The hospital worked with three neighbouring local authorities with regards to safeguarding and the referral protocols were clearly outlined and known by staff. Data provided by the trust showed that between April 2018 and March 2019 urgent and emergency services (both trust hospitals) made 207 adult safeguarding referrals and 856 safeguarding children referrals. In the safeguarding examples we reviewed and heard, staff displayed appropriate professional curiosity that contributed to protecting vulnerable patients. Concerns were well escalated and resolved using multi-disciplinary team (MDT) approach.

The ED had safeguarding advisors whose role was to provide advice and support to clinical staff. The advisors helped to assess and manage risks and concerns that staff identified about the safety and welfare of children and adults at risk. Staff described the advisor as being accessible, supportive, visible and helpful. A liaison social worker from the local authority was based at the hospital to provide advice and support to the emergency and other departments. Staff had a 24-hours access to social care.

ED staff attended a weekly psychosocial multidisciplinary team (MDT) meeting with other internal and external stakeholders including child and adolescent mental health services (CAMHS), social workers, named nurses, named doctors and neonatal staff. The aim of the meeting was to discuss complex cases, review care plans and discuss learning points.

Triage sheet had a safeguarding section for adults and children. The department carried out an annual audit of the management of children with safeguarding concerns. It was a retrospective audit of a randomly selected casualty cards of children between November 2018 and January 2019. The audit identified eight areas of good practice and six areas which required improvement. Areas of good practice related to:

- child protection registers being up to date and checked appropriately
- triage safeguarding screening tool being completed appropriately
- extensive and thorough history taking and documentation
- documentation of full physical examination
- documentation of clear description of injury
- appropriate referral to paediatrics where indicated
- referral/notification to social service done where indicated
- liaison form to health visitor / school / nursery was completed where indicated

Areas that required improvement were:

- documentation of child’s general appearance, behaviour and interactions
• documentation of full physical examination especially examination of the skin, ear/nose/throat and eyes
• use of body map in case of injuries
• consideration of the other children in the household
• growth assessment
• the completion of the clinicians’ safeguarding tool

The service used safeguarding adults and children screening tools completed at the different stages of the patient’s journey within the ED. Staff carried out a quarterly audit to monitor compliance. Safeguarding children screening tool audit focused on three areas:
• documenting ‘voice of the child’
• completion of the safeguarding screening tool on patient electronic system
• completion of clinician’s assessment

Safeguarding adults screening tool audit focused on three areas:
• completion of safeguarding trigger checklist
• completion of clinician’s assessment
• completion of discharge checklist

Compliance with the completion of the safeguarding screening tools for children and adults between October 2018 and June 2019 was good or improving, except for the ‘completion of clinician’s assessment’ section with the following results: 40-50% for adults, 23-28% for adolescent (16 to 17 year-old) and 72-76% for children.

A health visitor/school nurse liaison form was completed alongside a multi-agency referral form and a social care notification to inform the health visiting service/school nurse of a child’s attendance to the ED or admission to the paediatric ward. Health visitor/school nurse liaison forms were also completed if staff believed a family would benefit from their input, such as to support an anxious first-time mother, or to provide safety advice on accident prevention. Between October 2018 and September 2019 staff completed 1,001 health visitor/school nurse liaison forms, which was on average 2.7 forms per day. This indicated staff were vigilant and sharing information with the wider health care system.

Children who presented to ED with mental illness were referred to mental health speciality teams in alignment with the clinical pathway for mental health/self-harm. Psychosocial meetings were held weekly to discuss children with safeguarding concerns and families with vulnerabilities.

The trust policies for mental health, safeguarding and social care were easily accessible for staff. We also reviewed a number of documents in relation to safeguarding: mental health agreement and pathway, child protection pathway and flow chart, safeguarding screening tool, model for psychosocial meeting, policy for non-mobile babies and disabled children, domestic violence and abuse policy and pathway amongst others. These were accessible, comprehensive and up to date.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
The department had suitable furnishings which were clean and well-maintained. Sluice and cleaning cupboards were clean, tidy and securely locked with a numeric keypad. Treatment rooms, cubicles, bays as well as corridors across the department were clean and clutter free.

During our previous inspection cleaning schedules were not displayed. This time we saw that cleaning schedules were displayed, up-to-date and demonstrated that all areas were cleaned regularly. There was a 24-hour cleaning cover across the whole department and the domestic staff rotated through three shifts.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE such as aprons and gloves was easily accessible and stocked in all areas and we saw staff used PPE as required. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During our visit we observed staff washing their hands and using hand sanitising gel appropriately. All clinical staff we saw were ‘bare below the elbow’.

During our previous inspection we saw that hand sanitising dispensers for the public were not always well-placed. This time we saw there was a sufficient number of sanitising dispensers in the department, including at the entrance to the department and inpatient cubicles which were well placed.

As at the previous inspection, we found that arrangements for hazardous waste disposal, including sharps bins were in line with national standards; however, previously we found that four sharps bins had not been correctly labelled. This time we saw all sharp bins were labelled to show the date on which the container was assembled and who assembled it. As at the previous inspection, we did not see any overfull sharps bins. Disposable curtains were used in the bays and we found that these were clean, stain free and clearly dated.

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

There was a large shared waiting area for ambulatory patients presenting to urgent and emergency care awaiting triage. Triage is a process of determining the priority of patients' treatments based on the severity of their condition. We had some concerns about this area as clinicians did not have a good visibility of the waiting patients. A clinician who was streaming patients had a CCTV in their streaming pod to monitor the waiting area, however this could not be effectively done while they were with a patient. Moreover, the CCTV did not cover the whole place and we noted areas where visibility was obstructed. After we expressed our concerns to the trust, they addressed this by allocating a health care assistant (HCA) or a nurse to monitor and assist patients. The addition of a nursing staff to the area improved patients’ safety. Senior staff told us this was a permanent solution and the role would be shared between the department and the UCC provider.

Children who were streamed to paediatric ED waited in a separate waiting area which had audio and visual separation from the adult section. Children could easily be observed by staff at the nurses’ station, which meant that a deteriorating child could be spotted quickly and given prompt attention. However, the area was small and could quickly become overcrowded which had adverse impact on patient safety, experience and patient privacy. Staff told us this was one of the risks within paediatric ED. The paediatric ED had a triage room and seven cubicles which comprised of four trolley/bed/cot bays and three seated cubicles. There was a high dependency cubicle used for children ‘stepped down’ from resuscitation but still requiring observation.
Adult ED patients were mainly cared for on two sides: minors and majors. Majors area was used for patients with more serious illnesses or injuries. The majors area had 16 bays, including one bay which could be used as a high dependency bay facing the nursing station. There were three isolation rooms, two with doors and one with curtains. These bays could be adapted to accommodate a patient presenting with mental health (MH) issues. The majors area also had a MH assessment room. The resuscitation unit comprised of three bays and one them had equipment for both adult and paediatric resuscitation. The minors area had six cubicles; this was where patients with less serious injuries and illnesses were treated.

The department had a ‘Fit2Sit’ area (introduced in hospitals to stop patients lying down on trolleys if they were well enough to sit up) which was a small enclosed space with patients waiting to be seen by a clinician, awaited treatment or received treatment such as intravenous therapy. A nurse allocated to that area checked patients every 15 minutes. We had concerns about this arrangement, for example staff could not immediately see when a patient became agitated or unwell in between nursing rounds. We discussed our concerns with the trust, who immediately addressed this risk. Staff rearranged the available space in the department and created a new Fit2Sit area with an allocated bank nurse.

The service had a clinical observation ward, with six beds and six to eight chairs, located near minors. The ward was staffed by an ED nurse and, depending on the demand, a health care assistant (HCA) and a nurse from the discharge team. This provided a short stay, single sex facility for patients awaiting test results, requiring overnight observation or needing social services support for discharge. The observation ward was also used to reduce late discharges of elderly patients. There were strict exclusion/admission criteria and staff had to complete a checklist, including NEWS2 score, before a patient was admitted. The decision to admit a patient to the observation ward had to be signed off by a consultant and a nurse in charge. Most patients stayed only one night.

The department had a designated mental health assessment room for patients with mental health (MH) needs requiring assessment or treatment. The room was very basic and although it was designed to prevent a patient from harming themselves or others, staff told us it was only suitable for an assessment rather than observation. The room had a seat which was sturdy and secured to the ground however could only accommodate one person. There were no ligature points in the room. The room had two doors that could not be locked from the inside and there was a viewing window to monitor a patient. However, there was an area where the view was obstructed. Also, the room did not have a strip alarm around the walls. Staff told us that when a patient needed a medical assessment a security staff would stand by the door. If a patient presenting with MH problems was compliant and waited long time for a MH inpatient bed, they were allocated to a cubicle with a bed. Staff had a self-harm checklist to make sure the environment was safe for the patients before moving them to the cubicle; they removed any unnecessary equipment and made sure the room was free of ligature points. Staff carried out regular ED and psychiatric observations and checks.

The service had enough suitable equipment to help them to safely care for patients. Equipment had been safety tested and was in date. It was clearly labelled and stored in an organised fashion including in corridors. As at the previous inspection, we found no temperature control problems on this inspection. Staff checked and recorded temperature of rooms and fridges daily.

Resuscitation trolleys were easily available and located in different areas of the department. Trolleys were secured with a plastic tag, so it was clear if someone had accessed the resuscitation equipment. The trolleys were clean and well organised however we found that certain equipment (for example syringes) and ampules had different expiry dates. Although all were in date, it is not best practice to mix products with different expiry dates.
Assessing and responding to patient risk

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

Patients arriving by ambulance awaited triage in a corridor located near majors and resuscitation area. Between 11am and 5pm the service was piloting a mobile rapid assessment and first treatment (RAFT) model which was consultant led. Patients brought by an ambulance were handed over to ED staff and their brief history was taken so that a doctor could determine the most appropriate area where RAFTing would take place. Outside these hours a nurse triaged patients arriving by ambulance. The service used adapted ‘Manchester triage system’ whereby patients were categorised depending on their clinical presentation which determined how quickly they had to be seen by a clinician. This varied from ‘immediately’, for the highest priority patients, to four hours for non-urgent patients.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly. They knew about and dealt with any specific risk issues such as sepsis, venous thromboembolism (VTE), falls and pressure ulcers. As at the previous inspection, we saw VTE assessments were completed. Patients suspected of having a deep vein blood clots were assessed in the minors area. Staff assessed all patients in majors who met the assessment criteria for a falls risk and this assessment highlighted patients who required lying, standing, sitting blood pressure checks. Appropriate action was taken to mitigate risks of pressure ulcers. All patients expected to be in the department for more than a couple of hours were transferred from trolleys onto a bed and pressure relieving mattresses were available if required. Risk assessments completed by nursing staff were regularly audited. If an audit indicated a drop in the quality an additional training from a nurse specialist was arranged.

As at the previous inspection, we did not have concerns regarding the monitoring of adult and children vital signs. The trust used NEWS2 warning system which was the latest version of the National Early Warning Score (NEWS). It was a nationally recognised tool to identify deteriorating patients and escalated them appropriately. It is a simple aggregate scoring system in which a score is allocated to six physiological measurements: respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. The system can be used to identify acute deterioration, including sepsis and, if correctly used, can trigger review, treatment and escalation of care. Paediatric ED used an age appropriate paediatric early warning score to assess deterioration. We reviewed notes of seven patients who were in the department between three to seven hours. We saw that all scores were frequently recorded and correctly calculated. None of the patients needed to be escalated. A consultant in charge and a nurse in charge did 2-hourly ‘pit stop’ intentional rounds, similar to ward rounds, to review all patients and prioritise work.

At the time of the inspection, there were six patients who stayed in the department overnight. All had been seen by an ED doctor in priority order. High priority patients were seen immediately or within 20 minutes. Lower risk patients were seen within three hours. We saw that nursing staff frequently recorded observations to monitor that patients’ condition did not deteriorate. Staff shared key information to keep patients safe when handing over their care to others.

When the triage nurse suspected sepsis a flag was placed against patient’s name. This also prompted the nurse in charge to follow the sepsis assessment plan. Staff used sepsis screening tool and a ‘sepsis six’ bundle. The sepsis six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis. Two trolleys containing the essential equipment
for managing sepsis were available within the department. A patient initial assessment form had a sepsis screening box that staff completed at triage or ambulance handover. Management of sepsis was part of mandatory training package. Staff had to complete a face to face mandatory sepsis training as well as a yearly refresher eLearning module for sepsis in adults and children. Completion rates for nursing staff at the time of the inspection for all three modules was 97.9% and above. Medical staff did not meet the trust's 90% target for sepsis training with 85.1% completion rates for the face to face sepsis training, 83.3% for sepsis in children and 72.7% for sepsis in adults modules. The service had a sepsis lead who ensured staff were compliant with the training and carried out sepsis audits. The department recently appointed an ED sepsis nurse to improve management of sepsis and enable better multidisciplinary work between medical and nursing staff.

During previous inspection we noted that nurses were not specifically trained in mental health (MH) triage and did not use any specific MH tools or rating scales for triaging patients. This was still the case during this inspection. Staff recorded risks as part of the general assessment. At the time of the inspection a MH pathway and assessment tool was being reviewed and updated. Staff told us it was in the final stages of development and the plan was to have all relevant MH assessments in an electronic format. The service had 24-hour access to mental health liaison team and specialist mental health support. As at the previous inspection, patients with mental health needs were tracked through a patient electronic system whereby a flag was placed next to their name. Patients were categorised depending on clinical need, for example patients experiencing suicidal ideation were prioritised and required to be assessed within 10 minutes.

Police may detain a member of the public under Section 136 of the Mental Health Act 1983 if a person appears to have a disorder of the mind, are in a public place and present a risk to themselves or others. Police will take such detained persons to a place of safety which could be the mental health assessment room at an emergency department or a designated Section 136 suite in a hospital for assessment and further management. There were two section 136 suites in a nearby mental health trust, however spaces were not always available. Between October 2018 and September 2019, a total of 155 patients were brought to the department under section 136 by the police. When possible, a registered mental health nurse was booked. Staff told us if a patient were aggressive or violent police often stayed with them, if that was not possible security staff was allocated.

The median time from arrival to initial assessment was similar to or higher than the England median for 10 out of the 12 months from June 2018 to May 2019. February and May 2019 were the only months in the 12-month period when trust performance was better than the England average.

**Ambulance – Time to initial assessment from June 2018 to May 2019 at Barking, Havering, and Redbridge University Hospitals NHS Trust**

![Graph](graph.png)

(Source: NHS Digital - A&E quality indicators)

King Georges Hospital had an upward trend in the percentage of ambulance journeys with turnaround times over 30 minutes between 2018 to June 2019. Although during the inspection the
ambulance handovers were prompt, ambulance staff told us that they often wait 20 to 30 minutes. They also said they saw little change in turnover times since the new RAFTing model was introduced.

The percentage of journeys with a turnaround time over 30 minutes, increased month on month over the winter from November 2018 to January 2019. In January 2019, King George Hospital reported the highest percentage of 83.0%. From February to May 2019 percentages improved.

**Ambulance: Number of journeys with turnaround times over 30 minutes - King George, Ilford**

![Bar chart showing number of journeys with turnaround times over 30 minutes]

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - King George, Ilford**

![Line chart showing percentage of journeys with turnaround times over 30 minutes]

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2018 to March 2019 the trust reported 543 “black breaches”, with the highest monthly number (140) in January 2019.

![Bar chart showing number of black breaches by month]

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. The service introduced a departmental live performance dashboard which, as well as displaying the current status of the department, predicted the performance which correlated to staffing numbers. This way the service could adjust the staffing levels based on the changing demand.

The service employed three emergency nurse practitioners (ENPs) who were senior nurses specially trained to assess, diagnose and decide on the appropriate course of treatment for patients. Prior to the inspection the service employed two accident department assistant (ADA).

The number of nurses and healthcare assistants matched the planned numbers. There were three nursing shifts a day: early, late and night. The late (twilight) shift was a short shift (6pm – 2am) to support staff at a known busy period of the day. If there was an increasing demand staff rotated between different areas of the department. Minors area typically had a senior doctor, ENP and an ADA allocated each day. The ADA also assisted triage nurse to take blood or do ECGs. In majors area there was one nurse allocated to four cubicles, although staff told us that if they were short of staff they would have five bays per one nurse. Paediatric ED always had at least one and sometimes two paediatric ED nurses on shift. The service had a junior matron dedicated to paediatric ED. Observations ward had an allocated registered nurse and a health care assistant (HCA).

The trust had a rolling recruitment programme and continued their efforts to reduce vacancy rates. The trust went abroad and successfully recruited several nurses; senior staff hoped one of the nurses would be allocated to ED. During previous inspection the vacancy rate was 30%, at this inspection it reduced to 12%; this did not include three recently recruited nurses due to start work. Staff told us the vacancy rate for paediatric nurses was still high at 22% across both hospital sites. We noted that most vacancies were filled with bank and agency staff that were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

The table below shows a summary of the nursing staffing metrics within emergency department at King George Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td></td>
<td>16,911.5 (10.3%)</td>
<td>12,076.3 (97.4%)</td>
<td>8,454 (5.1%)</td>
</tr>
<tr>
<td>All staff</td>
<td>82.7</td>
<td>15.5%</td>
<td>18.4%</td>
<td>18.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>56.5</td>
<td>16.5%</td>
<td>25.2%</td>
<td>17.0%</td>
<td>16,911.5 (10.3%)</td>
<td>12,076.3 (97.4%)</td>
<td>8,454 (5.1%)</td>
</tr>
</tbody>
</table>
Nurse staffing rates within emergency department at King George Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were found in monthly rates for sickness rates and bank staff use.

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change. We were told that the trust had taken action in response to high sickness rates. However, they did not indicate how sickness rates had improved.

Monthly turnover rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019.

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change.
The trust only reported agency and bank usage rates for nursing staff working across both sites. The table below shows the agency and bank use for nursing staff working across both sites in emergency department.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All staff</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4,222.3</td>
<td>5,421.3</td>
<td>7,658</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. This could be an indicator of change.
Medical staffing

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

The service had enough medical staff to keep patients safe. Medical staff in emergency department rotated between the two trust hospitals. The service had low and reducing vacancy rates for medical staff. In the last two inspections the service had longstanding challenges in recruiting permanent ED medical staff. At this inspection, there had been increase in the number of permanent consultants employed by the trust with 14 out of 18 consultant posts filled. The medical staff matched the planned number. If there was an increasing demand staff rotated between different areas of the department.

Managers could access locum (agency) and bank doctors when they needed to fill gaps in the rota or sickness. Senior staff told us they mainly used their own inhouse bank staff. Managers made sure bank staff complied with the mandatory training before they started work. If a locum doctor was requested, managers made sure they had a full induction to the service. They required the agency to send a full copy of the mandatory training before they started work. However, review of the mandatory training showed the service did not have information for all locum doctors.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The paediatric ED had two paediatric consultants covering shifts from 8am to 4pm and 10am to 6pm. There were also four clinical fellows who worked exclusively in paediatric ED. The emergency department had a consultant cover between 8am and 2am. This ensured the department met the Royal College of Emergency Medicine (RCEM) standard around consultant presence. The RCEM states there should be a consultant present for a minimum of 16 hours a day. Since the last inspection, the service increased the consultant cover from 16 to 18 hours moving them closer towards a 24/7 model.

The service always had a consultant on call during nights and weekends. There was 24/7 paediatric consultant cover and a 24/7 paediatric registrar cover.

The table below shows a summary of the medical staffing metrics within the emergency department at trust level compared to the trust’s targets, where applicable. The trust did not report staffing metrics for medical staff at site level. Medical staff work across both sites. The trust reported staffing metrics for medical staff only at trust level.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>576.5</td>
<td>29.7%</td>
<td>17.0%</td>
<td>18.6%</td>
<td>45,090.2 ()</td>
<td>63,154.0 ()</td>
<td>11,529 ()</td>
</tr>
<tr>
<td>Medical staff</td>
<td>154.1</td>
<td>48.9%</td>
<td>17.3%</td>
<td>11.4%</td>
<td>45,090.2 ()</td>
<td>63,154.0 ()</td>
<td>11,529 ()</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and...
Medical locum tabs

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and sickness rates.

Monthly turnover rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019. This could be an indicator of change.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Senior staff were very proud of their staff retention rates. They told us that in the past two years they did not have a resignation of a non-consultant doctor unless they moved to a training post.

In April 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 45 whole time equivalent staff working in urgent and emergency care at Barking, Havering, and Redbridge University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>40%</td>
<td>21%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
The senior managers had sought to address the shortage in middle career doctors by introducing advanced nurse practitioner (ANP) and advanced clinical practitioner (ACP) roles. ANPs are registered nurses who have done extra training and academic qualifications to be able to examine, assess, make diagnoses, treat, prescribe and make referrals for patients who present with undiagnosed/undifferentiated problems. ACPs are allied health professionals (AHPs) who undertake similar training. The ACP was dedicated to paediatric and the service was in the process of training two more ACPs.

**Records**

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

As at the previous inspection, records were a combination of computer and paper treatment records. During this inspection staff did not report any issues with the two systems. While reception staff used two patient electronic systems, one for the trust and another for the UCC provider, staff said they were easy to use and navigate. Once a patient had been registered and triaged, the triage nurse printed out the first page of the patient record and attached it to a nest of paper records. A unique patient identifier was on each page of the record.

The electronic record system showed the patient’s journey through the department including times they were seen by different professionals and the discharge time.

The paper records included different risk assessments, observation chart, details of any blood test results, electro-cardiogram results and a record of medicines that staff administered. Diagnostic imaging results were on a computer system. Patients’ notes that we reviewed were comprehensive, legible and fully completed by both doctors and nurses.

As at the previous inspection, records were securely stored in trolleys. Records were kept in the department for one month before being send to an external storage facility. Staff told us a summary of patient’s attendance was always on the computer system. If staff required to review a full set of notes which was already archived, they had to make a request to administrative staff. Staff told us most of the time they received the documents within an hour.

**Medicines**

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

As at the previous inspection, we found medicines management within the service to be good and staff followed systems and processes when prescribing, administering, and storing medicines. However, we noted that although staff used a stamp with their name in the controlled drugs register they did not always sign their entries. This was not in line with *Controlled drugs: safe use and management NICE guidance [NG46] published in April 2016*. We flagged this with senior staff. Following the inspection, we saw that staff were reminded at the next staff meeting to sign the register alongside their stamp.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. The controlled drugs (CDs) were stored securely in locked rooms and were accessible only to authorised staff. CDs were checked twice daily by nursing staff.
The service had a dedicated pharmacist who visited the department daily for medicines top up and to replace stock delivered once a week.

We reviewed contents of resuscitation trolleys. Medication was in date and we saw evidence these were checked daily by staff. We reviewed a sample of controlled drugs, regular medicines and to take away medicines (TTAs) and found them to be in date. TTAs were recorded in a register and signed by two nurses. Balance stock was checked by nurses twice daily and audited by the pharmacist.

Staff recorded daily maximum and minimum temperatures of fridges and rooms where medication was stored.

As at the previous inspection, patient records contained appropriate documentation of medicines prescription and administration, and of allergies. Children’s weights were measured and recorded to ensure the correct dose was administered in relation to their weight. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

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

Staff knew what incidents to report and how to report them. Senior staff told us they reviewed incident forms every day. Analysis of the incidents and near misses reported by staff between October 2018 and September 2019 showed these were reported in line with the trust policy. Incidents had relevant and detailed outcomes which clearly showed actions staff took to mitigate further occurrences. Staff received feedback from investigation of incidents and met to discuss the learning opportunities and look at improvements to patient care. Senior staff told us a ‘topic of the week’ for a morning briefing was sometimes identified as a result of an incident or a cluster of incidents to embed learning. All staff we spoke with confirmed the they learned about incidents, lessons learned and actions during the morning briefing. They also received feedback after reporting an incident. Lessons learned from serious incidents were displayed in staff room and staff told us that a matron facilitated ‘lessons learned’ update each month. Managers investigated incidents thoroughly. We saw evidence patients and their families were informed of and involved in these investigations.

The trust told us the service did not carry out a formal audit related to instances of restraint and tranquillisation, however any restrain activities were discussed along with other MH incidences as part of a mental health governance MDT meeting. This was not in line with the trust’s Administration of Mental Health Act 1983 policy which required staff to quarterly audit the number of Mental Health Act incidents and breaches and themes that may arise. Senior staff told us following restraint staff completed an incident form. Review of trust incidents between October 2018 and September 2019 showed that out of 1,488 incidents reported by staff only five related to instances of restraint. Staff told us they frequently had to deal with violent and aggressive patients therefore the number of incidents related to restraint appears to be low. As at the previous inspection, we were not assured such incidents were consistently reported. This also meant there was insufficient monitoring of the use of restraint to ensure it was used proportionately and safely.
Staff attended divisional mortality and morbidity meetings. These were attended by nursing and medical staff at different grade levels including students. Also, the service had just started their own mortality and morbidity group; the first meeting was week before the inspection. The intention was to meet monthly. Staff presented two case at the meetings to share learning with others.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2018 to May 2019, the trust reported three never events for the emergency department one of them happened at King George hospital. The one incident reported by the department in May 2019 was classified under the category of “surgical or invasive procedure incident meeting SI criteria”. The incident related to a retained foreign object post procedure and happened when staff did not remove a needle guide from a cannula.

(Source: Strategic Executive Information System (STEIS))

King George Hospital reported eight serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2018 to May 2019. A breakdown of incidents by incident type are below.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident including delay meeting SI criteria</td>
<td>4</td>
<td>50.0%</td>
</tr>
<tr>
<td>(including failure to act on test results)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse/alleged abuse of child patient by third party</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Serious incidents were subject to root cause analyses which were thorough and included an action plan to prevent similar incidents from happening. The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and senior staff understood their responsibilities in relation to DoC. We saw this duty was correctly applied when a notifiable safety incident occurred. Staff contacted the patient and/or family to apologise and explain when things went wrong.

The service always had a regular security staff presence in the department. The trust had a zero-tolerance policy to bullying, abuse and violence. If a violent or abusive incident occurred staff initially cautioned patients or the public, if the behaviour persisted they could withhold treatment. Staff could put a ‘flag’ on the patient electronic system to indicate that a patient acted aggressively. If they attended the service again the flag would alert staff not to attend them alone. Staff told us that managing violent and aggressive behaviour was going to be the topic of the next ‘keep in touch’ training day (KIT day). If a patient required 1:1 presence of security, the service arranged for additional security staff. As at the previous inspection, security staff did not have any specific mental
health and mental capacity training. However, the security staff we spoke with demonstrated good awareness of mental health issues which they developed through experience. Medical and nursing staff completed mandatory face to face conflict resolution training; after that they had to complete a 3 yearly online training update.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The acute medicine division closely monitored incidents of patient falls and these were discussed at the divisional governance meetings. The trust piloted two initiatives, falls risk stickers and post fall huddle forms in ED to see if these would help in reduction of patient falls incidents. Data provided by the trust showed that the number falls incidents across the division had reduced from 54 in April 2019 to 30 in May 2019, 28 in July 2019.

Data from the patient safety thermometer showed that the trust reported four new pressure ulcers, no falls with harm and four new urinary tract infections in patients with a catheter from May 2018 to May 2019 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Barking, Havering and Redbridge University Hospitals NHS Trust**

1. Total pressure ulcers (4)

2. Total CUTIs (4)

1 Pressure ulcers levels 2, 3 and 4  
2 Falls with harm levels 3 to 6  
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service monitored the compliance with National Institute for Health and Care Excellence (NICE) guidelines at divisional level. They identified newly published and relevant to the service guidelines and ensured these were updated. If required relevant training was provided to staff.

Since the last inspection, the trust introduced ‘Rapid tranquillisation and management of acute behavioural disorder in adults in the emergency department’ policy which was in line with current guidelines including NICE: Violence and Aggression. Short-term management in mental health, health and community settings [NG10].

The department carried out regular audits, including national audits requested by the Royal College of Emergency Medicine (RCEM) and audits to support and monitor implementation of NICE guidance. The service had a clinical audit programme in place for 2019-20 which included care of children in emergency departments, major trauma audit (Trauma Audit Research Network - TARN), mental health - care in emergency departments and assessing for cognitive impairment in older people. At this inspection we found that all audits were on track and regularly reviewed.

The service used sepsis toolkit for emergency medicine that was developed jointly by the RCEM and the UK Sepsis Trust. The RCEM recommends a minimum of 80% of permanent staff should receive appropriate sepsis training which should be audited at least biannually. The service set the target higher at 95% and audited the compliance with the toolkit each month. If a staff member was not compliant they offered them additional training.

Medical staff carried out a number of local clinical audits to assess and improve effectiveness of care provided. For example, in the last twelve months staff carried out an audit of patients presenting with suspected community acquired pneumonia (CAP) or contamination rate of peripheral blood cultures. Staff undertook audits based on NICE and other guidelines such as management of urinary tract infection in females or antibiotic prescribing to check their compliance with the antimicrobial prescribing guideline. Staff also carried out regular audits to assess compliance with the local policies and operational and clinical practices for example falls, discharge, skin integrity checklist or handwashing audits. Each day of the week staff collated data for a different audit. Following an audit staff completed ‘corrective action plan for audit finding’ document which outlined summary of findings, corrective action to be taken, method of sharing information with staff and the date of the next audit.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.
We saw patients being offered food and drink where appropriate if they were in the department at mealtimes. Staff made sure patients had enough to eat and drink, including those with special nutrition and hydration needs. Hostesses offered ‘finger food’ and ergonomic cutlery for elderly and patients who needed support with eating. The Malnutrition Universal Screening Tool (MUST) was used to assess and monitor patients’ risk of being under nourished. Staff fully and accurately completed patients’ fluid and nutrition charts where needed.

In the CQC urgent and emergency care – type 1 service (type 1 services include emergency departments and may also be known as casualty or A&E departments) the trust scored 6.4 out of 10 “for being able to access suitable food and drink while in A&E, if they wanted to”. This was about the same as other trusts.

(Source: Urgent and Emergency Care – Type 1 service October 2018 – March 2019)

Pain relief

The Faculty of Pain Medicine standards say that a patient in acute pain must have an individualised pain plan appropriate to their clinical condition that is effective, safe and flexible. We found that assessment and timeliness of analgesia was suboptimal. Staff did not always assess and monitor patients to see if they were in pain which was evident from a pain audit, review of patient notes and our conversation with patients in the department.

The service had a guideline for the administration of single dose oral analgesia in the initial assessment/triage areas. This meant trained nursing staff could administer a pain relief to a patient when required. This related only to the general sales list (GSL) medicine such as paracetamol, ibuprofen and co-codamol 8/500mg. Staff had to document the treatment including name of the drug, the dose and time prescribed. The service did not audit this process therefore could not get assurance this was effectively implemented. Also, the service did not audit management of pain in a meaningful way. We reviewed the pain audit results and saw there were number of gaps in the data. It was not possible to establish whether the gaps related to staff not documenting when analgesia was administered, patient not being offered or refusing analgesia. From the data that was available (37 out of 75 records) the results indicate that 15 patients waited between one and five hours for analgesia. At the time of the inspection, we also noted significant delays in patients receiving pain relief. Of seven patients that we reviewed, four waited between one and five hours for analgesia. For example, patient whose pain score was 7/10 waited five hours while another patient whose pain was described as ‘severe’ waited almost four hours. Staff told us that pain score 1 or higher should be re-evaluated by a triage nurse after 15-30 minutes. We saw no evidence that this was happening. We spoke with patients after they were streamed or triaged and they told us that pain relief was either not offered or they received it after one to two hours.

In the CQC urgent and emergency care – type 1 service, the trust scored 6.2 out of 10 “for feeling that hospital staff did all they could to help control their pain, if they were in pain”. This was worse than other trusts.

(Source: Urgent and Emergency Care – Type 1 service October 2018 – March 2019)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
The service participated in relevant national clinical audits. Staff carried out a comprehensive programme of repeated audits to check improvement over time. In August 2019 the emergency services at both hospitals carried out 36 audits comprising of: 11 Healthcare Quality Improvement Partnership (HQIP) audits for 2018/2019, six HQIP audits for 2017/2018 and 19 other audits (non-mandatory national audits, local audits and quality improvement projects).

Managers used information from the audits to improve care and treatment and made sure staff understood information from the audits. These were regularly reviewed and discussed at the governance meetings and teaching sessions. For example, the department carried local audits on sepsis every two weeks to assess whether patients were receiving appropriate and safe treatment.

Data provided by the trust showed that between August 2018 and August 2019 between 76% and 90% of patients were seen, treated and discharged within four hours. There was a dip in performance in January and February 2019 due to winter pressures. This was better than the Queen’s Hospital, however, still below the national target of 95%. We saw senior staff closely monitored the performance, looked at possible causes and had an action plan to improve their performance.

From June 2018 to May 2019, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. The average unplanned re-attendance rate at the trust was 10.4% compared to an England average of 8.1%.

Unplanned re-attendance rate within seven days - Barking, Havering and Redbridge University Hospitals NHS Trust

![Unplanned re-attendance rate graph]

(Source: NHS Digital – A&E quality indicators)

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Practice development nurses (PDNs) supported the learning and development needs of staff within the emergency department by auditing their practice and identifying training needs. Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work.
Managers made sure staff received any specialist training for their role. All new staff had a full induction tailored to their role before they started work. New nursing staff attended a three-day comprehensive induction which included corporate welcome, orientation around the department and focused on knowledge, skills and practice. The knowledge, skills and practice programme included essential training, neurological observations, electrocardiogram (ECG), manual blood pressure competences, simulation of patient assessment, minor injuries, slings, knee braces, burns dressing amongst others.

Medical staff were complementary about the induction they had which they found to be comprehensive and not rushed. They said it was “brilliant” and that it exceeded their expectations. It included corporate induction, some of the mandatory training sessions, orientation, observation and lectures.

Agency staff also underwent induction and orientation prior to starting their shift. We observed induction of an agency nurse and they seemed well supported. The service kept copies of the agency nursing staff competencies but also did their own assessment to ensure they were competent for the allocated area. Senior staff told us any CV of an agency staff had to be approved by the clinical lead before they were allowed to work.

The PDN delivered triage training which comprised of one day training followed by 20 patients observed competency assessment. Triage staff started as ambulance assessors; to gain their competences they needed to assess at least ten major and ten minor patients.

Emergency nurse practitioners (ENPs) attended medical study days and addressed any additional learning needs with a consultant during feedback sessions.

Staff attended structured ‘keep in touch’ (KIT) training days four times a year and this included training on mental health, incidents, complaints, safeguarding, changes to practice, as well as specific topics such as dementia, domestic violence or knife crime.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Nurses followed the Royal College of Nursing curriculum and competency framework for emergency nursing to develop their competences in, for example, resuscitation, paediatrics, or mental health. When a staff member was allocated to a new area such as resuscitation they initially shadowed their colleagues until they were familiar and confident with their role and responsibilities.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Several nurses we spoke with told us they completed a university course founded by the trust. Unfortunately, due to funding only one out of six nurses that expressed interest secured a place on a recognition and management of the acutely ill child course. Staff told us that funding was an issue and some nurses paid for their own training courses and attended these in their own time. Senior staff tried to overcome the funding issues by offering alternative training opportunities. For example, they organised a pilot where an ED nurse worked in 136 suite at the local mental health hospital one day a week for three months, while the MH nurse worked in the ED to learn how to identify the unwell and sick patient. Staff was very positive about this learning opportunity and senior staff said they hoped this shared learning would continue.

The service upskilled their adult ED nurses in paediatric emergency care through different initiatives. For example, they invited nurses to a weekly teaching session. The session was delivered by an ED paediatric consultant and focused on different aspects of care and treatment, for example diabetic child, bronchiolitis or resuscitation. Also, every adult ED nurse attended at least one paediatric ‘keep in touch’ (KIT) training day per year.
The PDN created a development pathway for nursing staff in line with the RCN competencies. The pathway clearly showed how nursing staff could progress in their role and what skills and knowledge were required. Nurse were given opportunity to rotate between different departments within the hospital to gain skills and further their knowledge. For example, some staff worked on the children’s ward.

Senior ED doctors could pursue special interests, for example in endocrinology or ultrasound. Also, junior doctors rotated to different areas of the hospital, such as paediatric department, anaesthetic department or ITU to gain new skills and experience which positively contributed to patient care in ED. General ED doctors had additional teaching sessions in paediatrics such as asthma or sepsis. They also could attend a weekly paediatric simulation session where real case scenarios were presented.

The service was in the process of developing A&E academy for middle grade doctors who considered applying for a Certificate of Eligibility for Specialist Registration (CESR). The CESR is a route to entry on to the specialist register for those doctors who have not followed an approved training programme but have knowledge, skills and experience equivalent to the approved curriculum for their specialty.

As well as completing mandatory training, security staff completed training in managing violent patients and advanced restraint techniques. Medical and nursing staff were complementary about security staff and said they were “very good and helpful” when dealing with challenging behaviours.

While the service had an extensive and comprehensive teaching programme staff said it was difficult to forward plan teaching activities due to limited space and suitability of rooms that were available. As a consequence, clinical staff could not book some courses ahead of time as these appeared unavailable.

Managers made sure staff attended team meetings or had access to meeting minutes when they could not attend. Staff room had a ‘quick learning points’ notice board with a number of topics and key points to educate staff in some common areas such as asthma in children and adults. Senior staff identified poor staff performance promptly and supported staff to improve. Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 76.7% of staff within the emergency department at the trust received an appraisal compared to a trust target of 90.0%. For the period April to June 2019, 29.9% of staff have received an appraisal.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>1</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>50</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>156</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>47</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>0</td>
</tr>
<tr>
<td>All staff groups</td>
<td>254</td>
</tr>
</tbody>
</table>

However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams. Figures provided by the trust for medical staff were very low. We queried this with the trust and did not receive a response.
King George’s Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>45</td>
<td>53</td>
<td>84.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>57</td>
<td>69</td>
<td>82.6%</td>
<td>100.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

Trust wide staff working at both sites

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>10</td>
<td>16</td>
<td>62.5%</td>
<td>100.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

However, care should be taken when interpreting staffing rates due to small numbers of staff in some teams.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. We observed effective, kind and respectful communication between staff from different professions and different grades. Staff worked across different disciplines and with other agencies to care for patients. We heard several examples were staff used an MDT team approach to assess patients and find the best support and treatment for them, including patients with complex psychosocial and health needs.

Most staff said they received good support from other specialities within the hospital and there was good MDT work, although some staff said there were examples of some specialities working in silos and some delays in getting doctors to review an ED patient. We saw and heard several examples where ED staff worked well with other teams and specialities within and outside the hospital such as medical assessment unit (MAU), frail older persons advice and liaison service (FOLPAL), local mental health hospital, or psychiatric liaison team. Staff could contact speciality nurses for advice including asthma, chronic obstructive pulmonary disease (COBD) or epilepsy specialist nurse.
The trust worked well with the local mental health trust to improve care for children, adolescent and adult patients presenting with mental health issues. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The local mental health trust delivered a psychiatric liaison service to provide mental health assessments and referrals for patients aged 18 or over. The psychiatric liaison team were no longer based in the department although staff said they were still accessible and responsive.

The frail older persons advice and liaison service (FOLPAL) team provided comprehensive geriatric assessment for frail elderly people and sought to avoid admitting patients where possible. The team worked well with relevant community services and agencies including social services, physiotherapy, occupational therapy and a local charity for older people.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

Both adult and children emergency departments were open 24 hours a day throughout the year. Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services 24 hours a day, seven days a week.

Diagnostic imaging was available 24/7. If a patient arrived out of hours and diagnostic imaging was not urgent patients were given an appointment early the next day.

The service provided consultant cover seven days a week with consultants working between 8am and 2am. Outside these hours an on-call consultant was available.

Pharmacy services were available seven days a week with shorter hours at weekends. An on-call pharmacy service was available out of hours. Staff had access to emergency stocks of medicines at all times.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had limited information promoting healthy lifestyles and support in the waiting area, however, this area was managed by the UCC provider and not the trust. The service had leaflets for patients and carers about injury or illness aftercare and reassuring information for parents and carers about common childhood illnesses and signs of more serious illnesses to look out for. The department had information about diabetes, healthy diet, asthma care for young patients, amongst others. During hot weather the service gave advice to patients, in particular the vulnerable, to stay safe in the heat. The trust had a vision for the hospitals to be smoke-free and focused on encouraging and supporting patients to stop smoking. Where appropriate the trust promoted self-care and advised patients to look for over-the-counter remedies to deal with grazed knee, cough, colds and sore throats or to contact a local pharmacist for conditions such as diarrhoea, runny nose or headache.

In May 2019 the department rolled out a mental health awareness week. The department had a display which focused on staff and patients’ mental wellbeing and displayed various posters such as ‘stop the stigma’, ‘it’s ok not to be ok’.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They demonstrated good understanding of consent and capacity and knew who to contact if they were uncertain about patient’s capacity. They knew where to find policies and guidance on the trust intranet.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The nature of emergency medicine means that verbal rather than written consent us required on most occasions. We observed staff obtaining verbal consent and appropriately recording it when needed. When patients could not give consent, staff made decisions in their best interest.

Staff demonstrated good understanding of patients’ mental health (MH) needs. The service had a MH lead consultant that staff could contact if they required advice. They told us in the last year the department had done lots of work around MH awareness and best practice. Different aspects of MH problems were always covered during regular staff training days (KIT days). Examples of topics covered during KIT days included: managing patients who presented with mental health issues, importance of documenting what a patient was wearing, triaging, section 136 or MH observation chart. In May 2019 they organised a MH awareness week to raise awareness to all staff regarding mental health patients and their wellbeing while in the department. All teaching sessions for the month were focused on caring for patients who present to ED with mental health issues. In June 2019 medical staff had a MH themed teaching month. The service introduced emergency care mental health strategic group. Also, since the last inspection the trust introduced a weekly multidisciplinary meeting that focused on improving care and treatment for people with mental health needs who present to ED. The meeting was attended by internal and external professionals who played a part in caring for people with mental health problems. This included clinical commissioning group, police, ambulance service, young people service, drug project, local mental health trust as well as number of representatives from the trust. The group discussed ‘frequent attender’ at the emergency department and tried to find solutions for they circumstance so that they no longer relied on ED for non-emergency issues.

The mental health team or doctors carried out mental capacity assessments. If a patient was believed to have dementia, clinicians carried out a brief mental capacity assessment known as ‘mini-mental state’ assessment. The department had a consultant who was a lead in mental health. They were responsible for reviewing policies, procedures and pathways. They worked closely with the local mental health trust. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Information provided by the trust shows that between April 2018 and March 2019 the service made one urgent Deprivation of Liberty Safeguards (DoLS) application.

Staff understood ‘Gillick competence’ and ‘Fraser guidelines’ and supported children who wished to make decisions about their treatment. Nursing and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act (MCA) 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.
The trust set a target of 90% for completion of MCA and DoLS training. An MCA/DoLS e-learning package was introduced as essential training for all clinical staff that have contact with adults at risk. In addition to the e-learning, a number of face to face training sessions were delivered in clinical areas, at divisional quality and safety meetings and medical training sessions. A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at King George Hospital for qualified nursing staff in the emergency department is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>48</td>
</tr>
</tbody>
</table>

Qualified nursing staff in the emergency department at King George Hospital met the target for completion of MCA/DoLS training.

A breakdown of compliance for MCA/DoLS training courses from April 2019 to June 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>66</td>
</tr>
</tbody>
</table>

In the emergency department the target was met by medical staff.

A breakdown of compliance for MCA/DoLS training from April to June 2019 for qualified nursing staff in urgent and emergency care that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>11</td>
</tr>
</tbody>
</table>

Qualified nursing staff in urgent and emergency care working across both sites met the target for completion of MCA/DoLS training.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we saw and heard many examples of staff treating patients with compassion and dignity. We observed staff maintaining patients’ privacy and dignity during examination. Most patients said staff treated them well and with kindness. Two patients and their relatives, who said they would only come to this hospital, said they “wouldn’t go anywhere else” and that staff were “brilliant”.

The patient friends and family test (FFT) asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Barking, Havering and Redbridge University Hospitals NHS trust from May 2017 to April 2019 are shown below.

Havering and Redbridge University Hospitals NHS trust – response rate May 2017 to April 2019

![Chart showing response rates]

The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 56.3% and 91.2% from May 2017 to April 2019.

The data showed six points outside of the control limits and 12 unusually high/low data points. Additionally, for most of the period, the data showed that trust performance was potentially too stable and may be subject to too much control.
The trust provided site specific data between April and August 2019 which showed the response rates to the FFT for King George Hospital were above the trust target of 15%. The data showed a steady increase of the response rates with 18% in April to 21.8% in August 2019. Between April and August 2019, on average, 95% of respondents said they would recommend the service to their friends and family, this was above the trust target of 85%.

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. To indicate that a patient was end of life, deceased or received bad news a flickering LED candle was placed outside their cubicle. This alerted staff and other patients to be more sensitive and quieter as the patient and their loved ones might require peaceful time.

The trust had a multi-faith chaplaincy team who provided spiritual and religious care to patients, visitors and staff. The hospital had a prayer room and there was an on-call rota for a priest, rabbi and imam and staff could contact them via switchboard.

Most staff demonstrated empathy when dealing with patients and their loved ones although we were told by a patient of a situation where staff seemed to show little concern and care to a patient who was visibly in a lot of pain. Most staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

**Understanding and involvement of patients and those close to them**
Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The waiting area had information boards explaining patient journey and different pathways (majors, minors, UCC and paediatrics) and the queueing systems. Information about the staff uniforms were displayed so patients and their relatives could identify staff job roles. We observed staff introducing themselves by name and explaining their roles to patients.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care. For example, we saw a patient with suspected sepsis, they were immediately seen by a consultant who explained to them the treatment plan. The doctor calmly talked the patient through what they were doing whilst they were assessing and providing treatment. Patients and their families could give feedback on the service and their treatment and staff encouraged them to do this.

However, despite positive support and communication that we observed, the trust scored better than other trusts for none of the 24 emergency department survey questions relevant to the caring domain. The trust scored worse than other trusts for 12 questions and about the same as other trusts for the remaining 12 questions.

Some of the themes included in the questions where performance was worse than other trusts were confidence and trust in staff, talking to each other as if patients were not there, contradictions in information given, not involving patients in decisions and poor communication in terms of medical side effects and guidance on when to resume normal activities. All questions are in the table below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q31. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q32. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>4.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q34. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Overall</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. As at the previous inspection, ambulances did not bring some categories of patient to the department. These included children, certain cardiac patients, trauma, ophthalmology and gynaecology patients. However, the department treated walk-in children in the paediatric ED. Patients who attended ED requiring support from specialities that were unavailable at the hospital were assessed and stabilised before being transfer to Queen’s Hospital. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and those living with dementia. The service had systems to help care for patients in need of additional support or specialist intervention.

Facilities and premises were appropriate for the services being delivered. The waiting area had around 80 seats, television screens and an electronic display screen showing information about the journey through the emergency department. There was a coffee machine and vending machines for cold drinks and snacks.

The paediatric waiting area had a children’s play area with a good range of toys. The department received an annual donation of toys from the local fire station. At the time of the inspection the service was in the process of recruiting a play specialist.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The observational ward offered a single sex facility for patients awaiting test results, requiring overnight observation or needing social services support for discharge.

The department raised staff awareness of the ‘red bag scheme’ (typically used by care homes to improve communication between care homes and hospitals) for patients requiring end of life care. Staff room had information on the scheme including relevant information such as information related to ‘Do Not Attempt Resuscitation’ (DNAR), medication administration record charts, ‘this is me’, PEACE (proactive elderly advance care), palliative care team contact details, priorities of care of dying patient and advanced care planning info.

The service could produce leaflets in languages spoken by the patients and local community. Patient information leaflets were not on display in languages other than English, but there was a facility to translate these into 137 languages. Staff told us telephone translation services were always available and face to face translation could be arranged. Staff, patients, relatives and carers could get help from interpreters or signers when needed, and we saw language line being used although we also saw an example where a family member was used for translation.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The service had a pantry with basic refreshments for patients such as tea, coffee, juice, yogurt, toasts, porridge or breakfast cereals. A hostess attended long staying patients between 7am and 7pm every three to four hours. Patients were offered sandwiches however if they were staying long they were offered a hot meal. If a patient had any additional dietary requirements, such as vegan or gluten free, food was ordered from the hospital canteen. Paediatric ED had a bottle warmer so that parents and
carers could warm milk for their children. If required, they offered one of the treatment rooms to breastfeeding mothers.

The service relieved pressure on other departments when they could treat patients in a day. The frail older persons advice and liaison service (FOPAL) provided comprehensive geriatric assessment for frail elderly people, and sought to enable people to return home with support where possible. The hospital had a frailty pathway to avoid unnecessary admission for elderly patients. The service organised a high intensity user’s forum which was a multi-agency, multi-disciplinary meeting to discuss needs of frequent attenders and redirect them to more suitable services.

The service organised a collection of clean clothes that were available for homeless and vulnerable people.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service used stickers in patient notes so that staff could immediately identify that a patient might have additional needs.

Staff told us patients presenting with mental health (MH) problems were the biggest challenge for their service due to capacity and provision of suitable accommodation, especially in relation to child and adolescent mental health services (CAMHS) inpatient beds. Although staff said CAMHS was responsive, sometimes there were long delays to transfer a patient and this was outside trust’s control. To keep a MH patient safe staff would request an agency mental health nurse to attend and support care while they were awaiting transfer to a more appropriate accommodation. Staff said the longest wait for a young person in the department in the last twelve months was four days. Staff completed an incident form and a root cause analysis (RCA) investigation was carried out. If needed staff also used security guards for high risk patients. Staff had access to a duty psychiatrist and adolescent outreach team from a local MH trust. Staff said the MH team were responsive and accessible. A patient could get an assessment within an hour during the day and two to three hours during the evenings. Adult patients waiting long time for an inpatient bed in the local mental health hospital were allocated to a cubicle with bed.

The service had a dementia lead nurse and a learning disability link nurse that staff could contact for advice. Staff completed dementia e-learning course, and a dementia lead nurse delivered training to staff during KIT training day. Staff were aware that the ED environment was not dementia friendly, but they tried to support patients with their experience and skills. The trust dementia team organised a twiddle muff knitting competition for staff. The twiddle muffs were available in the ED and staff could offer them to patients living with dementia. If required a patient was provided with a hospital bed to make them more comfortable or to prevent pressure sores.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust signed up to a mental health charity to demonstrate its commitment to improving patient experience for people with a learning disability accessing hospital services. The trust was compliant with all principles of the charter. Staff supported patients with a learning disability with provision of patient hospital passports. At the time of the inspection, 97.7% of patients with a learning disability had access to a hospital passport which was
an improvement from the previous year (89.6%) and 100% of patients with a learning disability had an electronic alert added to the hospital computer system by a learning disability liaison nurse team.

The trust had ‘learning disability champions’ who worked across the organisation. The role of the champions was to provide advice and support in the clinical setting for staff and patient. The trust’s learning disability liaison nurse team supported staff to improve their skills and knowledge around the needs of people with a learning disability. Learning disability awareness training was provided on trust induction training for all nursing staff. Training focused on the definition of a learning disability, communication needs, reasonable adjustments and use of hospital resources for people with a learning disability including the hospital passport and easy read information. During induction training staff received a ‘12-point learning disabilities’ information sheet. Autism awareness e-learning was essential training for all hospital staff to complete. This included a video of good and poor communication techniques produced by the learning disability liaison nurse team. It also provided an awareness of sensory sensitivity and sensory overload for people with autism. Data from March 2019 showed that 91.7% of staff completed the training. Staff had access to communication aids such as picture cards and colour cards to support communication with patients when required. We saw these being used. Staff told us that patients with a learning disability were given higher priority to reduce the time in the department which staff understood could be distressing for them. Staff said the learning disability team was supportive.

The waiting area, streaming pods and consultation rooms for ambulatory patients were large enough to accommodate patients with wheelchairs and pushchairs. The waiting area had comfortable chairs and during the inspection we saw there was enough seating for the number of patients who attended. There was a digital display informing patients there were three different queues. Signage explained that priority was given to clinically urgent cases therefore patients might not be seen in the order they arrived. Waiting times were not displayed but staff told us reception staff informed patients about anticipated waiting times. Most patients we spoke with did not know how long they would wait although they said they expected the waiting times to be long and did not express any concerns. In the CQC urgent and emergency care – type 1 service, the trust scored 2.7 out of 10 “for those who waited to be examined, being informed how long they would have to wait”. This was worse than other trusts.

(Source: Urgent and Emergency Care – Type 1 service October 2018 – March 2019)

Toilets and baby changing facility were clearly signposted. There were TV screens displaying popular shows with subtitles.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients attending the ED independently were initially assessed by a clinician from the co-located urgent care centre (UCC). The streaming clinician assessed patient’s condition and if necessary took some observations. Depending on patient’s presentation, the clinician streamed (directed) patients to the GP at the UCC, to the paediatric ED (for children under 16 years old) or to the adult ED. Patients were given a different colour card showing where they were streamed to: yellow for paediatric ED, blue for minors, red for majors or a green card for the GP service. Patients were then required to present the card to the reception staff to register. Any child or adult considered by the streaming clinician to be very unwell was referred direct to paediatric ED or majors with registration being done
later. This meant the sickest patients went through the system without delay. Remaining patients who required ED treatment waited for assessment by a triage nurse, usually band 6 nurse. Staff told us that if the waiting area became increasingly busy with many patients waiting to be triaged, they would deploy another triage nurse to improve the patients flow and reduce waiting times.

The service could not precisely monitor how long patients were waiting from the moment they arrived to being streamed. Although new ticket machines had been purchased so that waiting times could be measured more precisely this was not in use. During the inspection we observe patients being seen immediately by a streaming clinician when they arrived to waiting 15 minutes.

Patients arriving by an ambulance were triaged once they had been registered onto the hospital patient electronic system. Triaging staff could not enter patient’s details onto the system before the registration was completed. This meant there was around five minutes delay from the time a patient arrived and was being registered to being triaged. We saw that some staff commenced triage and noted any details on a piece of paper whilst registration was underway. This way they avoided unnecessary delays, however this was not the case most of the time. The service worked with the ambulance service and clinical commissioning group (CCG) to improve ambulance handover times. Data provided by the trust showed that since the introduction of the mobile rapid assessment and first treatment (RAFT) model in July 2019 the ambulance handover times improved from approximately 25% of patients waiting over 30 minutes to be handed over to approximately 15% in September 2019. We observed variable efficiency of RAFTing that depended on which clinician carried it out, however this was still in the pilot stage and the service continually reviewed the process.

During the inspection the department did not experience overcrowding and we observed generally good patient flow within the service. Despite some patients occupying bays whilst waiting for social care package or transfer to another speciality the patient flow was not disturbed. In the mornings there were always empty cubicles for patients to go to, although staff told us they frequently faced pressure and large influx of patients. The service introduced 2-hourly ‘pit stop’ intentional rounds carried out by a consultant in charge and a nurse in charge to identify and resolve ‘bottle necks’ and improve patient flow within the department. On the morning of our inspection we saw five patients who had been in the department for more than 4 hours (between five and twelve hours). On review of their notes we saw that all patients were reviewed by an ED consultant and their delays were due to complex needs which the service was addressing.

The trust reviewed the emergency department, trust wide and whole system escalation plans and worked on improving the application of the full capacity protocol. If there were significant bed shortages and the pressure on a service became too high, the hospital declared an internal incident which meant it would need to restrict some services to focus greater resources on emergency care. Trust wide bed management meetings were cross site and took place three times a day. During this meeting, both hospitals discussed the number of patients in ED, staffing levels, any ED breaches and bed capacity. This allowed the trust to identify capacity issues, and ways to resolve these. In addition, nurse and consultant in charge did two hourly ‘pit stop’ intentional rounds to identify and address holdups in the flow in the department. Senior nursing staff were aware of the ED escalation plan and hospital full capacity protocol; they knew what action should be taken in case of overcrowding and restricted capacity. When the protocol had been used it had positive impact on reducing overcrowding within department. For example, staff told us that a week before the inspection the department exceeded its capacity. We reviewed the related incidents and saw that staff followed appropriate escalation process and maintained patients’ safety.

If a patient needed to be treated by a medical care doctor they were transferred directly to a medical assessment unit (MAU) provided that beds were available.
The department had frail older persons advice and liaison service (FOPAL) comprehensive geriatric assessment for frail elderly people, seeking to avoid admission to the hospital. The service was offered to patients who were 75 years old and over or were frail and had comorbidities. FOPAL also run a follow-up service for discharged patients. The team had links with all relevant community services and was able to complete a package of care within few hours of patients attending the department.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in any of the months over the 12-month period from June 2018 to May 2019 and was also worse than the England average throughout the period.

Median times from arrival to treatment at the trust ranged from 77 to 115 minutes compared to the England median times of 56 to 66 minutes. The trust reported the longest median times in the winter months of January (115 minutes) and February 2019 (112 minutes).

**Median time from arrival to treatment from June 2018 to May 2019 at Barking, Havering, and Redbridge University Hospitals NHS Trust**

(Source: NHS Digital - A&E quality indicators)

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards. The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From July 2018 to June 2019 the trust did not meet the standard and performed worse than the England average. Except for January and February 2019, trust performance against this metric followed a stable trend. The average percentage of patients admitted, transferred, or discharged within four hours at this trust was 80% compared to the England average of 87%.

**Four-hour target performance - Barking, Havering, and Redbridge University Hospitals NHS Trust**
From July 2018 to June 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.

From July 2018 to June 2019 performance against this metric followed a stable trend.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Barking, Havering, and Redbridge University Hospitals NHS Trust

(Source: NHS England - A&E SitReps).

Over the 12 months from July 2018 to June 2019, 54 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in April (13) and June 2019.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>73</td>
<td>0</td>
</tr>
<tr>
<td>Aug-18</td>
<td>79</td>
<td>0</td>
</tr>
<tr>
<td>Sep-18</td>
<td>78</td>
<td>0</td>
</tr>
<tr>
<td>Oct-18</td>
<td>70</td>
<td>1</td>
</tr>
<tr>
<td>Nov-18</td>
<td>82</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)
<table>
<thead>
<tr>
<th>Month</th>
<th>This Trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-18</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>Jan-19</td>
<td>136</td>
<td>8</td>
</tr>
<tr>
<td>Feb-19</td>
<td>132</td>
<td>10</td>
</tr>
<tr>
<td>Mar-19</td>
<td>76</td>
<td>5</td>
</tr>
<tr>
<td>Apr-19</td>
<td>57</td>
<td>13</td>
</tr>
<tr>
<td>May-19</td>
<td>84</td>
<td>5</td>
</tr>
<tr>
<td>Jun-19</td>
<td>70</td>
<td>12</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

From June 2018 to May 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than the England average. However, care should be taken when interpreting the graph below, the margins between the trust and England percentages were less than 1.5% for months where the trust performed better and months where the trust performed worse than the England average.

From March to May 2019 the trust reported to the NHS Digital that no patients left the trust before being seen. However, further data requested from the trust showed that between March and September 2019 this rate remained similar to the previous months and varied between the lowest score of 2.7% in May 2019 to the highest score of 4.4% in July 2019.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - Barking, Havering and Redbridge University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

From June 2018 to May 2019 the trust’s monthly median total time in A&E for all patients was higher than the England average.

From June 2018 to May 2019 performance against this metric showed an upward trend, peaking in January and February 2019, before falling and stabilising from March to May 2019.

Patients at the trust spend an average of 217 minutes in A&E compared to the England average of 157 minutes. The longest time spent in A&E at the trust was in the winter months of January (236 minutes) and February (234 minutes). The England average time spent in A&E for January and February 2019 was 164 and 165 minutes.

Median total time in A&E per patient - Barking, Havering, and Redbridge University Hospitals NHS Trust
Senior staff attributed the longer stays in the winter months to significant winter pressures in terms of the number of patients arriving into the department and delays in patients being admitted to other specialties due to shortages of available beds.

**Learning from complaints and concerns**

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Managers investigated complaints and identified themes. These were discussed at a monthly divisional governance meeting with clearly outlined learning points for staff. We reviewed a sample of three redacted complaints from 2019 which identified how the trust investigated and resolved these. The letters offered an apology, summarised an outcome of the investigation and if the complaint was upheld or partially upheld it explained what action was taken. Managers shared feedback from complaints with staff during team briefings and learning was used to improve the service. The ‘topic of the week’ for the morning briefing sometimes was identified as a result of increase of a specific type of complaint to embed learning and improve practice.

From April 2018 to March 2019 there were 52 complaints about urgent and emergency care at King George Hospital. The trust took an average of 31.0 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be answered within 25 days.

A breakdown of complaints by type is below:
<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>18</td>
<td>34.6%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>10</td>
<td>19.2%</td>
</tr>
<tr>
<td>Communication</td>
<td>6</td>
<td>11.5%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>6</td>
<td>11.5%</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>4</td>
<td>7.7%</td>
</tr>
<tr>
<td>A&amp;E waiting times</td>
<td>3</td>
<td>5.8%</td>
</tr>
<tr>
<td>Patient event</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>Privacy, dignity, and discrimination</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Security</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Theft</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

In the twelve months prior to the inspection the service received two formally recorded compliments.
Is the service well-led?

Leadership

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

The service was part of the acute medicine division within the trust. The division was led by a triumvirate: clinical director, divisional nurse and divisional manager. They reported to the trust board through the chief operating officer.

The trust had two emergency departments, both were run by the same local leadership team: lead nurse, general manager and clinical lead. Locally, the service was led by an adult matron, newly appointed paediatric matron and lead consultants for adult and paediatric ED.

Staff told us most divisional and local leaders were visible and some had a set day when they visited the service and spoke with staff. All staff received an open invitation to a drop-in session with a senior nurse where they could ask them any questions. Staff told us local leadership team was supportive, approachable and engaged.

Vision and strategy

The service had a vision for what it wanted to achieve and was in the process of developing a strategy to turn it into action.

Staff we spoke with were aware of the trust’s values. The values were based on the acronym ‘PRIDE’, which stood for passion, responsibility, innovation, drive and empowerment. These values were visible across the hospital and on the hospital’s website.

At the last two inspections we found a lack of clarity on the vision and strategy at department level. Around a month prior the inspection the service launched a vision for the service which was: ‘to provide high standards of care to our community, delivered with PRIDE in a clean, safe and friendly environment’. The service was in the process of developing its clinical strategy. They had organised two workshops for staff to discuss how the service was going to look like in the future.

Senior staff had several local plans to develop the department to meet the needs of the population they served. For example, the service had seen an increase in patients presenting with mental health (MH) problems attending the service but had only one mental health assessment room which was substandard. They were in the process of designing a new MH suite and developing a strategy for mental health patient experience.

Some staff expressed concerns about the uncertainty of what was going to happen with the department. Some nursing staff worried about how and by whom they would be managed. Staff were concerned about future plans for minors area which had given them some anxiety and created uncertainty.

Culture

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

As at the previous two inspections staff morale was good within the service. Some said they would or did bring their family members to the hospital or had their treatment there. Staff felt proud of the team work and felt they could rely on their colleagues. Staff said that senior managers regularly visited the department. They said the matrons were supportive and understanding, and when possible offered flexible work arrangements due to personal circumstances. When staff was required to complete mandatory training outside working hours they were either paid or received additional time off. Staff described a ‘no blame’ culture in relation to reporting clinical incidents and talked about the importance of reporting incidents to improve the service. Medical staff were complimentary about their nursing colleagues and said that even in high pressure situations they handled work with a smile and good cooperation.

Following a distressing event there was a routine debrief organised by senior staff to emotionally support those involved and learn best practice. Staff gave us good examples of when a group and individual debrief took place.

The service had a positive culture which focused on achievements, celebrating success and learning opportunities if something went wrong. This was evident in governance meeting minutes and different achievement awards that individuals and teams received. The service introduced many initiatives to improve staff wellbeing and morale. The department rolled out a ‘shout out’ comments box where peers could anonymously compliment a member of staff for any instances of noble practice such as providing exceptional care, being supportive, maintaining cheerful demeanour in difficult situations amongst others.

One of the topics of the week in the department was ‘staff appreciation week’ where staff focused on appreciating each other, motivation and support.

The ED matron recognised exceptional staff performance by awarding them ‘star of the month award’. A photo of the awarded staff member and their colleagues was displayed in the department each month.

Staff told us about a baking competition, curry week, meditation Mondays and stress awareness week. In May 2019 the department rolled out a mental health awareness week. Following the awareness week staff created a display in the department which focused on staff and patient’s mental wellbeing and displayed various posters such as ‘stop the stigma’, ‘it’s ok not to be ok’.

The department had a LGBT display in one of the corridors which aimed to raise awareness of LBGT agenda. The display included explanation of the terminology (transgender, pansexual, intersex, gay, lesbian, bisexual) and pledges to accept LGBT staff and patients as equal explaining why this was important. Staff wore LGBT badges and senior staff were committed to raising awareness of LGBT agenda.

**Governance**

Leaders operated effective governance processes within the service although governance arrangements with a partner organisation required further development. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had an effective governance structure, processes and systems to support the delivery of good quality care. Information from divisional meetings was cascaded to staff through a range of
communication methods such as email, newsletters and meetings. Review of the acute medicine divisional governance meeting minutes showed the service was patient-focused, used information to improve quality and standards and looked at effective and efficient ways to develop staff. For example, the service recognised they needed to improve the way they supported patients presenting with mental health problems. They introduced several initiatives to achieve their commitment such as mental health awareness week, additional training and teaching sessions or introduction of different multidisciplinary meetings.

The service held a monthly quality, safety and business meeting which was also attended by the provider of the urgent care centre (UCC). During the meeting staff discussed incidents, risks, clinical effectiveness (audit results), key achievements, finance, any points that required escalation to the divisional governance meeting and any other issues.

The senior management of the service attended two governance meetings per month with the UCC. However, we felt that governance arrangements between the trust and UCC provider required further development. For example, the trust did not audit whether patients were appropriately streamed to ED and UCC. The initial steps of patients’ pathway attending the hospital such as streaming, or registration was done by the UCC provider. We noted that streaming staff were not always bare below elbows, were dressed casually in jeans and did not wear name badges. While this part of the patient journey was not provided by the trust it involved trust patients. We also noted that there were still some processes between the two providers that needed strengthening and clarification. For example, there was a number of patients attending the service because they could not get an urgent appointment from their local primary care service. If these patients were inappropriately streamed to the emergency department, staff could not divert them back to UCC without GP’s approval. Staff told us GPs sometimes refused their request, which in turn had a negative impact on patient’s experience and put additional pressure on ED service. ED staff relied on reception staff to inform them if there were any issues with staffing of the streaming service.

Staff attended their specific band/role team meetings. For example, emergency nurse practitioners (ENPs) met regularly to discuss their progress, any concerns, rota, learning needs and how to incorporate additional training sessions. Band 6 and band 7 nurses had their own separate team meetings. If a staff member could not attend a meeting they received feedback via email.

The trust had an effective safeguarding governance structure. The chief nurse was the executive lead for safeguarding representing the trust at the local safeguarding adult and children boards across the three local boroughs. The director of nursing, safeguarding and harm free care, was the lead for the safeguarding team. Named professionals within the team represent the trust at the local safeguarding adult and children board subgroups and committees. The safeguarding strategic and assurance group met quarterly and was chaired by the chief nurse. The purpose of the group was to obtain assurance that robust systems and processes were in place to safeguard children and adults and that the trust met their statutory and legislative requirements. The trust's safeguarding operational group combined the safeguarding adults, children and learning disabilities agendas to promote a 'think family' approach and support the trust's safeguarding strategy.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Although they did not always identify all relevant risks and actions to reduce their impact. They had plans to cope with unexpected events.
Most staff had a good awareness of challenges and we saw evidence the service tried to mitigate risks. Senior staff reviewed the departmental risk register monthly. The risk register had only three risks which related to: doors to patient bathrooms which could not be opened if someone collapsed behind them, delays in undertaking rapid assessment and obsolete patient trolleys. We saw that the risk register did not reflect all the risks identified by us or shared by ED staff, some of them related to patient safety. For example, the risk register did not include paediatric waiting area which was small and could quickly get overcrowded. Also, ‘Fit2Sit’ area which we identified as not fit for purpose, or the main ED waiting room which had areas where a view was obstructed, were not on the register. Some staff told us they considered overcrowding and capacity of the department as one of their top risks. This was highlighted to us during the previous inspection. The department frequently exceeded its capacity however overcrowding was not listed on the register.

At the previous inspection, insufficient medical staffing remained a high risk. During this inspection the trust made a significant progress and filled 14 out of 18 consultant posts. The trust also reduced nursing vacancies including paediatric nurses. There was a system in place to ensure safe staffing. Senior staff analysed the acuity of patients and capacity of each area and moved staff accordingly.

Staff reported that a week before the inspection the department exceeded its capacity. We saw staff completed three incident forms in relation to that and a full capacity protocol was in effect. Staff maintained patient safety and leadership team showed good support and visibility on that shift. Incidents related to capacity were grouped together and discussed at the local and divisional clinical governance meetings.

Staff told us the service had a learning culture. They felt encouraged to report incidents with a view to improve the service and learn. If there was a drop in performance, for example increase of falls, or gaps in documentation, staff received training. Although the service did not audit agreed streaming pathways, incidents of incorrectly streamed patients were reported. Senior staff analysed these incidents and discussed them with staff to highlight any learning points.

The service had a specialty improvement plan to improve the time it took for specialities to respond to a request for a patient review. The service recorded percentage of patients reviewed by each speciality within 30 minutes. This was discussed at the divisional governance meetings and a daily email was sent to each speciality highlighting the results.

A major incident plan was available on the intranet. This plan provided clinical guidance and support to staff on treating patients in the event of different kinds of emergency incident. The service had a major incident cupboard which stored emergency equipment, including decontamination equipment if needed.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Senior staff could monitor service’s key performance indicators through a live performance dashboard. The dashboard displayed information about number of patients arriving, number of admissions, four-hour breaches, average time patients stayed within the department, longest time in the department and number of available adult beds in the hospital amongst others. This helped senior staff to assign staff to the busiest areas to improve patient flow.
There were sufficient numbers of computer terminals for staff to access electronic patient records or trust intranet. The trust and senior managers used email and social media to share information with staff. Staff could also access information via the intranet, where links were available to policies and standard operating procedures.

As at the previous inspection, ED treatment records were paper based. Staff had to photocopy all the paper records for patients requiring admission. The remaining paper treatment records were not scanned onto an electronic system until archiving stage. If staff required, the archived records they could obtain these usually within one to two hours. Staff did not report issues or concerns with regards to access to information and patient records.

**Engagement**

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

Staff told us they were informed and consulted on plans for the ED areas. They were invited to provide feedback on, for example reconfiguration of paediatric ED, relocation of observation area or new design of MH assessment area.

The service engaged with the public through different initiatives including: 'you said, we did' boards and information on the trust website. In August 2019, patients were encouraged to contribute their views on the future of the service. The trust was developing a clinical strategy which would set out how they could meet the growing demand and changing needs of their patients. Patients could share theirs views via an online survey.

Staff told us they were active on social media where they posted information about their achievements and tried to promote the trust brand. Senior staff analysed friends and family test (FFT) results and responded to patients’ comments. For example, they replaced chairs in the waiting area. Senior staff said they monitored FFT response rates on a weekly basis. If they saw decrease in responses, they reminded staff to encourage patients to complete the test. They also put posters in staff room to reiterate the message.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

We found the service to have a good learning culture. Senior staff introduced several initiatives to encourage and support learning. The service had a ‘topic of the week’ learning update which happened every day during the morning briefing. Each week was dedicated to a different subject which varied between clinical to interpersonal and personal skills and knowledge. For example, staff wellbeing, medical management of different conditions and presentations, dementia or falls amongst others. Topics were also selected as a result of an incident or when knowledge gaps were identified. The teaching was interactive and fun to engage and motivate staff and took form of games, challenges and quizzes. For example, staff talked about infection prevention where five most common bacteria and viruses were discussed. Then staff had a task to use correct personal protective equipment to prevent its spread.
The service was in the process of establishing an A&E academy which would help middle grade doctors to obtain Certificate of Eligibility for Specialist Registration (CESR).

The service had a recognised research unit and several clinical staff members were active in research to improve patient outcomes. They were involved in different projects including work on early detection of sepsis, ultrasound of fractures or cardiac arrest.

One of the ED consultants came up with an idea of a knitting competition to make twiddle muffs for the department to benefit patients living with dementia. It was also a fun and positive activity which gave staff opportunity to make a difference and support their patients.

To improve recruitment process and attract staff the service created a short video where potential candidates could see ‘a day in the life of ED’.

Staff room had an information board with details on ‘what we’re doing well’ and ‘what we’re wanting to improve’. The aspects of work staff were proud of doing well were: safeguarding adults and children, sepsis management, dementia care, autism awareness, team working, and low numbers of complaints amongst others. The areas for improvement were: friends and family test response rates, prompt response from mental health (MH) team, ensuring good care of patients presenting with mental health problems who were awaiting MH bed and nurse vacancy rates and staff retention.

King George Hospital

Critical care

Facts and data about this service

The trust has 63 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Barking, Havering and Redbridge University Hospitals NHS Trust and England.

(Source: NHS England)

King George Hospital

King George Hospital has one intensive treatment unit (ITU). As at March 2019, there were 30.0 nursing Whole Time Equivalent (WTE) staff and 1.3 administrative and clinical WTE staff. (Source: Routine Provider Information Request (RPIR) Acute – Context tab)
The critical care service at King George Hospital consisted of an eight-bedded critical care unit (CCU) providing care at level two (high dependency) and level three (intensive care), to adults who required a higher level of care than could be provided on the wards. Level two patients were nursed 1:2 and level three were nursed 1:1. The trust had a consultant led critical care outreach team (CCOT) delivered by specialist nurses to support the needs of acute and deteriorating ward and emergency patients on both sites.

The trust provided acute and chronic pain services by multi-disciplinary teams including consultants, specialist nurses and allied health care professionals across both sites. The chronic pain team provided a range of interventional treatments, medication and delivers a pain management programme which offered patients the tools to manage pain and improve their quality of life.

Between August 2018 and August 2019 there were 632 admissions to the CCU.

At our last inspection in 2015 we found reduced staffing levels numbers with changes in patient acuity, which meant patients were not always supported on a one to one basis as per national guidance. We also found little evidence of multidisciplinary team approach and governance.

During our inspection, we spoke with 20 members of staff including clinical leads, doctors, nurses, senior managers, support staff, pharmacist and physiotherapists. We reviewed the healthcare records of four patients and spoke with three patients and relatives.

### Is the service safe?

#### Mandatory training

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

The trust set a target of 90% for completion of all mandatory training courses except for information governance which has a target of 95%.

#### Trust level

Medical staff worked across both sites. The trust did not report mandatory training completion rates for medical staff at site level. A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>24</td>
</tr>
<tr>
<td>Fire safety</td>
<td>52</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>47</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>47</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>46</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>46</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>44</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>44</td>
</tr>
<tr>
<td>Information governance</td>
<td>43</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>43</td>
</tr>
</tbody>
</table>
Resuscitation level 2 - paediatric basic life support | 14 | 28 | 50.0% | 90.0% | No

Trust level data showed that critical care met the target for two of the eleven mandatory training modules for which medical staff were eligible.

We asked the trust how they were addressing non-compliance of mandatory training in medical staff. The trust told us medical staff were required to attend 70% of the quality and safety meetings and the weekly teaching sessions. The trust had an action plan to identify non-compliant staff and set a timescale to achieve compliance. Each task in the action plan had a named lead, progress and target date for completion. Recurrent non-compliance would be escalated to the division’s triumvirate team for action.

**King George Hospital critical care department**

A breakdown of compliance for mandatory training courses from April to June 2019 for qualified nursing staff in the critical care department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>30</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>30</td>
</tr>
<tr>
<td>Equality, diversity, and human rights</td>
<td>30</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>30</td>
</tr>
<tr>
<td>Fire safety</td>
<td>29</td>
</tr>
<tr>
<td>Health, safety, and welfare</td>
<td>29</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>14</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>28</td>
</tr>
<tr>
<td>Information governance</td>
<td>28</td>
</tr>
<tr>
<td>Resuscitation level 3 - adult immediate life support</td>
<td>13</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>26</td>
</tr>
</tbody>
</table>

King George Hospital critical care department met the target for eight of the eleven mandatory training modules for which qualified nursing staff were eligible. After the inspection, the trust submitted the September 2019 compliance rates for nursing staff. The data showed improvements had been made with 96.7% for information governance was 96.7%, 100% for basic life support (BLS) and 100% intermediate life support (ILS).

**Trust wide nursing staff that work across both sites**

The trust reported compliance for mandatory training courses for qualified nursing staff, that worked across both sites, under a separate trust wide section. A breakdown of compliance for mandatory training courses from April to June 2019 is shown below:
Qualified nursing staff, working across the critical care department at both sites, met the target for all nine mandatory training modules for which qualified nursing staff were eligible. (Source: Routine Provider Information Request (RPIR) – Training tab)

Staff told us they received protected time to complete the mandatory training either at work or staff could access the training at home and get time back. Managers and staff received email reminders for any training due to expire with plenty of notice to complete it.

Staff told us the training was delivered via e-learning and some modules were face to face. For example, sepsis training was both face to face and via e-learning.

Safeguarding

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

Safeguarding training was incorporated into staff’s mandatory training. The trust set a target of 90% for completion of safeguarding training.

Trust level

Medical staff worked across both sites. The trust did not report safeguarding training completion rates for medical staff at site level. A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>49</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>48</td>
</tr>
</tbody>
</table>

Trust level data showed that critical care did not meet the target for any safeguarding training modules for which medical staff were eligible.

After the inspection, the trust submitted the current compliance rates for March 2019 to August 2019 which showed improvements have been made. The compliance rate for safeguarding adults’ level 2 was 90% and safeguarding children level 2 was 92%. The trust told us that only nursing staff (band 7 and above) were required to complete safeguarding adults’ level 3 training; hence
medical staff within critical care were not required to complete it.

King George Hospital critical care department

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 for qualified nursing staff in the critical care department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>26</td>
<td>26</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 3</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>29</td>
<td>30</td>
<td>96.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

King George Hospital critical care department met the target for all safeguarding training modules for which qualified nursing staff were eligible.

Trust wide nursing staff that work across both sites

The trust reported compliance for safeguarding training courses for qualified nursing staff that work across both sites, under a separate trust wide section. A breakdown of compliance for safeguarding training courses from April to June 2019 is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff within critical care, working across both sites, met the target for both safeguarding training modules for which they were eligible. *(Source: Routine Provider Information Request (RPIR) – Training tab)*

Staff told us they had access to the trust’s adult and children’s safeguarding policies and procedures via the staff intranet. We found the policies were in date and included information on individual responsibilities and the process to follow for reporting and escalating concerns about a patient’s welfare.

The service incorporated information about female genital mutilation (FGM) in their procedures. All the staff members we spoke with were able to identify abuse and demonstrated consistent awareness of FGM.

The unit had a dedicated link nurse for learning disability and dementia and staff could also access support from the trust’s safeguarding team. The safeguarding team’s contact details were displayed near the reception desk including out of hours contact for staff. The trust’s safeguarding adult team included the director of nursing (for safeguarding and harm free care), named nurse, named doctor, lead nurse for learning disabilities for adults, two safeguarding adults’ advisors (of which one was for Mental Capacity Act and Deprivation of Liberty Safeguards), safeguarding adults secretary and two emergency department safeguarding advisor.
Staff told us the use of chaperones depended on the individual patient as the unit allowed two visitors per bed space. For elderly patients, staff encouraged the next of kin’s to be present where needed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

All areas we checked were visibly clean with no clutter in the corridors. We inspected various items of equipment, such as commodes, electrocardiogram (ECG) machine, pat slide, hoists and chairs and found a good level of cleanliness. We checked a sample of toilets on the unit and found them to be visibly clean. The service used ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use. All the equipment and stickers we sampled were clean and the date was recorded except for the ultrasound machine. We found that although the ultrasound machine had a ‘I am clean’ sticker, the probe had blood on it and was sticky with the ultrasound gel. We reported this with the senior nurse who confirmed the machine had not been used for two days and ensured the equipment was cleaned immediately.

Handwashing facilities and alcohol gel were available outside the entrance for the unit with a notice for visitors to wash their hands before entering. Further hand washing facilities and alcohol gel dispensers were located throughout the unit near both side rooms and on the bay.

Hand hygiene audit results from March 2019 to May 2019 showed that the CCU consistently achieved 100% compliance. However, in June 2019, the unit achieved 63% compliance. The audit documented recommendations for the CCU and improvements were seen as the unit achieved 100% compliance in July and August 2019.

We observed all staff groups, including consultants, were bare below the elbow and actively washed and sanitised their hands before and after contact with patients in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). The unit had sufficient access to personal protective equipment (PPE) for staff to use.

The trust had a service level agreement with an external contractor to provide cleaning services. Staff told us they called the porters when deep cleans for bed spaces were required. Curtains were changed when the patient left the unit or if a deep clean was requested in line with trust policy.

The unit had a notice board dedicated to infection prevention and control (IPC) which displayed a poster on “five moments of hand hygiene” informing staff of best practice, information on needle stick injury and Methicillin-resistant Staphylococcus aureus (MRSA) decontamination. The trust’s IPC team completed monthly audits for hand hygiene, environment, devices and provided IPC training for staff. For example, the team had provided recent face to face training on blood cultures and covered topics such as aseptic non touch techniques. The IPC team told us they were involved in staff inductions for medical staff, nursing staff and the domestic cleaning team.

The IPC results for July 2019 showed the unit achieved 100% for clinical audit, hand hygiene, PPE, decontamination of equipment, commodes compliance and catheter audit. The CCU achieved 98.4% in the standards of cleanliness audit for August 2019.

Between April 2018 and March 2019, the CCU reported zero incidences of unit-acquired MRSA, C.difficile and vancomycin-resistant enterococci (VRE).

Staff we spoke with demonstrated awareness of Carbapenamase producing Enterobacteriaceae (CPE) screening and told us CPE training was included in staff inductions. CPE screening is required if a patient is admitted from another hospital or abroad in line with guidance from NHS
England and Public Health England (2013). Staff told us the IPC team supported the unit when a patient was admitted with CPE.

Isolation procedures were in place for patients with infections by using the side rooms. Staff told us that in event of a patient being isolated, the side room would be marked clearly to alert staff and visitors with instructions of the precautions to take prior to entering the side room.

**Environment and equipment**

The critical care unit was secure. Entry to the critical care unit (CCU) was via an intercom entry system and staff key card access only. Staff members checked the faces of visitors before granting entry and where the visitors were new to the unit, staff would go and greet them in the reception lobby. We observed these systems be used consistently. Security staff also visited the CCU to check on the staff in the morning and at night.

There were effective systems in place for the safe management and disposal of waste products. Each bed space had a clinical waste and pharmaceutical bin next to it. There was also a functioning sluice within the unit. Sharps bins throughout the unit were readily available, clearly labelled and not overfilled, and we saw that waste was labelled and handled appropriately.

The intubation trolley checklist was up to date and all items on the trolley were in date. The negative pressure airflow system in each side room was working effectively. The main airflow alarm system for the unit was also in working order.

Although nursing staff completed weekly checks on the critical care network transfer bag, we found the end tidal CO$_2$ (EtCO$_2$) indicator was missing. Staff told us the unit did not have any in stock since end of August 2019. We raised this with senior leads who told us the service should have in hindsight, produced a more suitable local checklist for the unit instead of using the standardised checklist provided by the network, which had items that were not applicable to them. The service was currently assessing the need to have an EtCO$_2$ indicator in the transfer bag.

The estate presented challenges for the unit to comply with the new building regulations. Senior leads told us the priority was to maintain infection prevention and control, isolating patients appropriately with consultant input. Other issues regarding the environment would be escalated to estates team.

Although most of the equipment we observed had service date stickers, we found two equipment items which included a Barton transfer chair, that did not have a service date. We raised this with senior leads who told us the manufacturer had not put service stickers on the equipment as it was new and service stickers were usually added after the first service. However, the service leads told us they would address this with the manufacturer.

The trust provided the equipment maintenance log which had been updated in September 2019. We found each entry in the log had an equipment number, device type, brand, serial number, date of last service, date when next service was due and location of the equipment. The log showed that most equipment items were in date and included notes against items where the service was due.

Physiotherapy staff told us they had no issues with getting equipment such as walking frames, walking sticks, hoists and seats. Although the hospital had enough bariatric equipment, staff told us that there were delays at times to locate bariatric chairs within the hospital. Staff would call the site manager when bariatric equipment was required who would then call each ward to locate the item.

The trust provided the staff training rates for 21 medical devices/equipment for August 2019. The data showed the CCU achieved 100% compliance rates for 13 of the medical devices/equipment.
such as NG tube checking, tracheostomy and defibrillator. The CCU achieved 97% for six devices, 90% for patient-controlled analgesia, 100% for medicines management and 63% for the ITU course.

Assessing and responding to patient risk

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

The critical care outreach team (CCOT) supported acutely ill patients in other areas of the hospital, prior to their transfer to the CCU, all patients in the hospital with a tracheostomy, or to follow up on patients discharged from the CCU. The CCOT was consultant-led with one lead nurse (band 8a) and nine outreach nurses (band 7). Although the team was based at Queens Hospital, there was always at least one specialist nurse based at King George Hospital, which could be increased to two specialist nurses if the unit was busy.

The CCOT provided cross site cover seven days a week from 7.30am to 8pm. The team completed reviews of the electronic observation chart three times a day and actively reviewed all patients with a National Early Warning Score (NEWS 2) greater than seven. Each morning, the CCOT had a handover at 7.30am with the site manager to discuss each patient including any unwell patients from the previous night. The CCOT also provided an overnight handover to the clinical site manager and intensive care unit (ICU) doctor where a review was needed. If needed, the CCOT could provide out of hours support for ward staff and ICU doctors.

Senior leads acknowledged that the service was not compliant with mandatory training for resuscitation level 3 in medical staff and this was included on the trust’s risk register for the critical care service. Data between April and June 2019 showed the compliance rate for resuscitation level 3 (adult immediate life support) in medical staff at trust level was 51.7% against trust target of 90%.

The divisional performance review meeting minutes for May 2019 stated the trust was organising in house training sessions with the lead resuscitation officer to address this.

The compliance rates for nursing staff was 100% for both immediate life support and basic life support. Although the CCOT team achieved 80% for advanced life support, the trust told us the team would achieve 100% by November 2019.

Sepsis (adults) was part of the trusts mandatory and statutory training. Data provided by the trust between April to June 2019 showed that 76.8% of medical staff and 100% of nursing staff (against trust target of 90%) had completed the training. Staff we spoke with demonstrated awareness of how to recognise and assess the symptoms of sepsis.

The service completed VTE audits weekly. Between March 2019 and August 2019, data showed the CCU achieved 100% consistently except for three occasions where non-compliance was due to a missed assessment.

The unit did have occasions where the patients were violent towards staff. Staff told us they would call the security team who were responsive to keep both staff and other patients safe. Staff also involved families and referred patients to Independent Mental Capacity Advocate (IMCA) if needed. IMCA is a role created by the Mental Capacity Act (2005) to support and represent the person in the decision-making process. Staff told us the response times for an IMCA could take up to 24 hours.

Although the intubation trolley had an up to date checklist with all items in date, there was no difficult airway equipment on the unit. Staff told us they would go to theatres to get the emergency kit. We raised this with senior leads who informed us there has not been an issue to date in obtaining from theatres located nearby when needed. Although the senior leads acknowledged that in event of an emergency it would be helpful to have an emergency intubation kit on the unit, they told us the kits
were not used often. Staff told us an individual approach was adopted. For example, if a patient came from the emergency department, there would be documentation that the patient was intubated and any notes if intubation was difficult. In this case, an emergency intubation kit would be kept on standby.

Staff carried out frequent monitoring of a patient’s condition and charted the results, looking for signs of deterioration. Staff we spoke with were able to recognise when a patient’s condition had deteriorated and understood when to follow the escalation process. Staff told us they would inform the nurse in charge who would then assess the patient and inform the ICU consultant and registrar. The unit used an electronic observation system and the monitor for all the patients was located behind the reception desk.

Intensive Care National Audit Research Centre (ICNARC) data between April 2018 and March 2018 showed the unit only had one patient admitted who was under 18. Staff told us the unit had not admitted 16 to 18 year olds for some time. The layout of the unit included with one bay with five beds and two side rooms which allowed the service to segregate patients if needed.

Safety alerts were circulated corporately via the compliance team to the senior leads and matrons. Senior leads told us the alerts would say if the information was relevant for trust or which department and who the information had been shared with. The safety alerts were tracked via the patient safety group.

**Nurse staffing**

Although there was a high vacancy and sickness rate for nursing staff, the service ensured there were enough nurses with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The table below shows a summary of the nursing staffing metrics within critical care at King George Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>43.6</td>
<td>25.8%</td>
<td>15.6%</td>
<td>30.6%</td>
<td>5,213.2 (6.7%)</td>
<td>966.9 (1.2%)</td>
<td>2,943.0 (3.8%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>39.9</td>
<td>25.9%</td>
<td>16.9%</td>
<td>31.2%</td>
<td>5,213.2 (6.7%)</td>
<td>966.9 (1.2%)</td>
<td>2,943.0 (3.8%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within critical care were analysed for the past 12 months and showed no indications of improvement, deterioration or change in the monthly rates for vacancy, turnover, sickness, and agency use.
Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*

The trust’s critical care service was managed by a lead nurse (sometimes referred to as matron). The CCU at King George Hospital had four band 7s of which one was the manager for the unit. The remaining three band 7s were leads for sub teams, each with an allocation of band 6s and band 5s to ensure equitable work load amongst the team. Each lead managed their sub team completing appraisals and training and development needs. If the leads needed to raise concerns, they would raise them to the manager for the unit who would then inform the trust’s lead nurse for critical care.

The Faculty of Intensive Care Medicine (FICM) Core Standards for Intensive Care Units states that all level three (patients requiring advanced respiratory support alone or basic respiratory support with support of two other organ systems) patients are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care. For level two (patients requiring more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure) patients a ratio of 1:2 is required. We reviewed patient allocation records and staffing during our inspection which showed the CCU complied with the required staffing levels.

Nursing staff worked shifts from 7.30am to 8.00pm, nightshifts from 7.30pm to 8.00am, late shift from 12.00 to 8pm and some staff did a short shift 7.30am to 3.30pm. Each shift had one band 7, one to two band 6s, four to five band 5s and a health care assistant. Nursing staff had two handovers each day. We attended a nurse handover and found it was detailed and structured discussing issues such as infection control issues, allergies, family issues and safeguarding. Staff were allocated to patients based on their skills and experience and received a detailed overview about their allocated patients. This was followed by a handover between the nurse in charge for the previous night and nurse in charge for the day and included staffing update and any other issues that needed to be addressed.

The nursing team also had weekly huddles where day and night staff attended to discuss any concerns, learning from complaints and incidents, staffing issues and complex patients. Senior leads told us that if staff were needed at King George hospital, the team could liaise with Queens Hospital and the CCOT for support. Staff told us the CCU used a social media platform to stay in touch and advertise any shifts that required filling.

The FICM Core Standards recommends no more than 20% agency staff usage per shift. Data provided by the trust showed that agency staff use on the unit had been 1.2% between April 2018 to March 2019 which was compliant with the FICM standard.
The unit had 13 vacancies for band 5s, 0.6 for band 6 and one healthcare assistant. Senior leads told us that permanent staff worked bank staff and where necessary, regular intensive care unit (ICU) trained agency staff were used. The trust had uplifted the bank shifts rates for band 5 who would get paid at band 6 rates. On occasions where the unit had a surge in acuity, the nurse in charge would complete a risk assessment on staffing based on the beds and if necessary, take on the responsibility of a patient and log this as an incident. Trust data between September 2018 and August 2019 showed there were 15 incidences where the nurse in charge was required to take a patient.

There was a senior bleep holder on weekends who was based at Queens Hospital and would check in with each unit to check staffing levels. The site manager also provided support during night shifts.

The last recruitment drive for critical care was in November 2018 which had resulted in some new starters. The trust planned to tackle the long-standing workforce challenge for recruiting band 5s by implementing band 5 rotations across all critical care units from October 2019. Senior leads felt this would help staff learn new skills and facilitate collaborative working.

Between April 2018 to March 2019, the provider information request (PIR) presented the trust’s annual sickness rate as 31.2% against the trust target of 4%. Senior leads told us the high sickness rates were due to one staff member on long term sick, one staff member on maternity leave and one staff member on short term sick.

Senior leads told us they managed sickness using trust’s policy to ensure consistency and fairness. The trust used an electronic roster system which ensured that staff members who had either short- or long-term sickness periods were not able to book bank shifts until after an interim period. The interim period for short term and long-term sickness was two weeks and one month respectively. Staff could be referred to occupational health for wellbeing support. Senior leads told us they wanted to ensure staff had appropriate work life balance with workable and flexible rotas. Staff told us they received their rotas two months in advance.

**Medical staffing**

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

**Trust level**

Medical staff worked across both sites. The trust reported staffing metrics for medical staff only at trust level. The table below shows a summary of the medical staffing metrics within critical care at trust level compared to the trust’s targets, where applicable.

<table>
<thead>
<tr>
<th>Critical care annual staffing metrics</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Group</strong></td>
<td><strong>Annual average</strong></td>
</tr>
<tr>
<td></td>
<td><strong>establishment</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual vacancy rate</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual turnover rate</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual sickness rate</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual bank hours (% of available hours)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual locum hours (% of available hours)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Annual unfilled hours (% of available hours)</strong></td>
</tr>
</tbody>
</table>
The trust did not supply the total available hours for medical staff. We could therefore not calculate rates for bank, agency, and hours unfilled. *(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)*

Medical staffing rates within critical care were analysed for the past 12 months and showed no indications of improvement, deterioration or change in the monthly rates for sickness.

Monthly vacancy rates over the last 12 months for medical staff showed a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

Monthly turnover rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019. *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

Staffing metrics between April 2018 to March 2019 showed that the sickness rate for medical staff at trust level was 15% against the trust target of 4%. We asked the trust how they were addressing this and were told the unit at King George Hospital had a low sickness rate with only two doctors reporting sick between March 2019 and August 2019. The trust told us the unit had a low turnover and vacancy rate considering the size of the unit and the number of speciality doctors. The unit had seven speciality doctors who worked across both sites to ensure they had access to the wider team. After the inspection, the trust submitted data for March 2019 to August 2019 which showed 84 shifts were covered using in house bank medical staff.

Although medical staff worked across both hospital sites, medical staffing was included in the trust
wide critical care service risk register. The CCU had a long term vacancy for two critical care consultants which the service managed through internal cover or local locums.

During the daytime shift (8am to 6pm), a middle grade doctor (registrar) supported the critical care consultant on duty. Overnight, a registrar was responsible for the unit with support from two on call consultants and the anaesthetist registrar in theatres if needed. The unit had an intensive care unit (ICU) registrar dedicated for the day shift and the night shift.

The on-call provision included two consultants of which one was based on site at Queens Hospital until 11pm and available remotely thereafter for telephone advice. The second consultant was available remotely for telephone advice. However, junior doctors told us they could easily contact the on-call doctor who would come on site to support. Medical staff told us the unit was not as busy as it used to be.

Although the day consultant at King George Hospital would provide a handover to the on-call consultant based at Queens Hospital, the on call consultant also had to cover the four critical areas in Queens Hospital. The cardiac arrest bleep was shared between anaesthetists and ICU doctors which could potentially affect the response times to arrests (especially if the ICU doctor was busy on the unit). However, junior doctors told us there was adequate support on the CCU.

Doctors completed a formal ward round twice each day and decided upon a management plan for each patient; this was in line with recommendations by the FICM Core Standards for Intensive Care Units.

The service recognised that retention of medical staff was a challenge and mitigated this by supporting junior doctors with their development and training. For example, two junior doctors had successfully completed the Certificate of Eligibility for Specialist Registration (CESR) programme after which one of the candidates had been appointed in a substantive role at the unit. CESR is the alternative route of becoming a fully qualified specialist in the UK. The CCU had several overseas senior doctors with anaesthetic backgrounds which optimised the skill mix. Consultants praised the standard of the staff grade doctors who covered the unit.

**Records**

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

The service used handwritten patient healthcare records. Each patient had observation records showing hourly information such as vital signs (such as blood pressure and temperature) and fluid balance. Although the unit used an electronic observation system, the service did not record observations electronically. Senior leads told us discussions were ongoing to source a reliable electronic system specific for the critical care service.

The CCOT used an electronic database to record their outreach reviews and printed paper copies for the patients records.

We reviewed four sets of patient notes and found records were mostly clearly written and dated, with legible signatures. Patient records were comprehensive, thorough and recorded evidence of input from nurses, doctors, allied health professionals and other specialities such as urology. We found that patients had their care needs risk assessed and appropriately recorded, with risk assessments completed including nutritional risk assessment, falls prevention, acute pain management, skin and
catheter bundles. For example, we saw evidence that visual infusion phlebitis (VIP) assessments were completed daily.

Where patients were discharged or transferred out of the unit, there was a specific handover sheet / discharge summary from the medical team and a separate one for nursing staff. We checked one discharge summary for a patient discharged during the inspection and found it was fully completed, contained all necessary information and was easy to understand.

We observed that patient's observation records and folders were kept at their bedside on a trolley. They were not locked away as they were in constant use by staff and monitored closely. We observed that computer screens at the reception desk and the computer on wheels were locked when not in use.

**Medicines**

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

Pharmacists were responsible for reviewing medicine charts to check prescriptions were correct and for drug interactions and allergies. Pharmacists completed medicines reconciliation within 24 hours and obtained drug histories from at least two sources. Medicines reconciliation is the process of identifying the most accurate list of all medicines that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medicines obtained from a patient, or GP.

The pharmacist also tried to attend each multidisciplinary team (MDT) ward meeting to provide clinical input. Pharmacy support staff visited the CCU to complete stock checks daily and check expiry dates. Nursing staff also checked expiry dates each time a medicine was used. We randomly checked five stock medicines and found that packaging was intact, medicines were in date and stored according to the manufacturer’s recommendation. The pharmacy and nursing staff told us the communication book worked well for obtaining additional medicine stocks.

Although the medicines room itself was not locked, it was located behind the reception desk which was always staffed and each cupboard inside the room including the fridge was locked. The keys were with the nurse in charge. Oxygen cylinders were appropriately stored in the storage areas within the unit and all the cylinders we checked were in date. Patient’s own medicines were stored in individual secured lockers at the patient bedsides. One key opened all medicines lockers on the unit. A general key was held by each nurse on duty.

The unit used an autonomous computerised cabinet (Omnicell) to store intravenous equipment such as blood administration sets. The cabinet was accessed by staff fingerprint and had a system to track stock levels with the stores department in the hospital. The cabinet displayed a guide on what to do in event of a power failure with contact details for the trust contact and out of hours. Staff told us they had had no issues with the cabinet and the system worked well.

The unit stored intravenous (IV) fluids in a separate cupboard which was locked, and the keys were kept with the nurse in charge. Staff told us this was an improvement from the last inspection. We found the IV fluids were stored neatly and labelled. Although nursing staff checked the expiry dates for IV fluids with additional spot checks from the pharmacist, we found two IV bags (sodium chloride) which had expired in August 2019. We raised this with the nurse in charge who removed the items immediately and completed an incident form.
Records showed that staff checked the temperature of the storage room for intra-venous fluids and the medicines room daily. Documentation for July and August 2019 was completed without any omissions. The temperature of each room was consistently within the desired range except for one entry where the temperature was out of range. However, the documentation showed the staff member took the appropriate action.

The pharmacy team completed monthly safe and secure storage of medicine audits where compliance against 15 secure storage medicines standards was assessed. The report for July 2019 showed the trust overall achieved 91% and the anaesthetics division (which included critical care) achieved 95%, against a target of 100%.

Controlled drugs (CD) were stored in a lockable, wall-mounted unit behind the reception desk and the keys were kept with the nurse in charge. The work station for checking CDs was always kept clear. CD balance checks were completed twice daily by two nurses. The CD book was stored within the CD cupboard. The book was neatly and accurately completed, and there were no missing entries or signatures. We randomly checked five CDs and found quantities matched the CD register and the medicines were in date.

Staff told us patient's own CDs were segregated and stored in the CD cupboard. Staff recorded each CD item on a separate sheet in the CD register for each patient which meant patients' own CDs were kept separate from stock balance. The pharmacy team completed CD compliance audit reports monthly where compliance against 19 CD standards was assessed. The report for June 2019 showed the trust overall achieved 95% and the anaesthetics division achieved 97%, against a target of 100%.

Emergency medicines were stored on the resuscitation trolley near the reception desk within the unit. We found the trolley was adequately stocked with all items on the checklist present and in date. We saw evidence of daily checks that occurred to ensure the seals had not been broken and weekly checks for the expiry dates for the contents within. The unit had three resuscitation boxes which contained emergency medicines and each box was in date (October 2019).

Nursing staff we spoke with were aware of trust policies on medicines management including administration of controlled drugs. Staff told us they could access these policies and procedures via the staff intranet. Staff could access the British National Formulary on either their mobile phones or a hard copy near the reception desk.

The pharmacy team were involved in training student nurses and junior doctors on commonly used medicines in critical care and IV fluids. Although the unit did not have many medicines incidents, the nursing staff and pharmacy staff told us learning was shared across both sites.

The pharmacy team completed monthly medication safety thermometers. For example, between May 2018 and August 2019, 100% of patient had their medicines’ allergy status documented.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2018 to May 2019, the trust did not report any never events for critical care. *(Source: Strategic Executive Information System (STEIS))*
However, during the inspection, we were informed of a never event that had been detected and reported on 22 May 2019. A retained guide wire had been detected six weeks following a central venous catheter (CVC) insertion despite the patient having 27 x-rays and 4 computerised tomography (CT) scans. Although staff were aware of the incident and told us the incident had been discussed at a team huddle, communication regarding the action points was poor and the revised checklist had not been implemented fully during the time of the inspection in September 2019.

The revised checklist included a step in the sign out box titled ‘guidewire removed’ and ‘chest x-ray requested’. During the inspection, senior leads told us the checklist changeover had not taken place fully and there was no awareness of the timelines for implementation. Some departments were still using the old checklist for cost effective purposes. However, senior leads told us that 200 updated checklists were expected to be delivered during the inspection.

Given the trust had had historical never events which involved guide wires, staff we spoke with were not aware of any National safety standards for invasive procedures (NatSSIPs) or Local Safety Standards for Invasive Procedures (LocSSIPs) in place. We raised this with senior leads who told us the service had a NatSSIP which could be found on the intranet. Although the NatSSIP had been in place since February 2018, we could not locate it on the intranet easily. Staff we spoke with could not find it either as it was not available in all the relevant areas for which the NatSSIP would be appropriate. For example, the NatSSIP was found within surgery department on the intranet but was not included in other relevant departments such as the emergency department or the intensive care unit (ICU) where a CVC could be inserted.

During the inspection, the divisional director of nursing told us that an additional email had been sent out to anaesthetists and matrons with a copy of the NatSSIPs, the revised checklist and other correspondence regarding the never event.

We requested the 72 hours report and the root cause analysis (RCA) report. We found the investigations were detailed with appropriate individuals involved and evidence that duty of candour requirements were met. The investigation report was reviewed by the clinical commissioning group (CCG) where queries were raised. The trust wrote to the patient to explain the reason for delay. The CCG advised the trust to reclassify the incident as a never event instead of a serious incident which led to a delay in reporting. Hence the investigation report date was 23 July 2019.

The RCA report included the following action points: implementing the revised checklist, updating the intensive treatment unit (ITU) manual to ensure all lines are removed prior to an x-ray being undertaken in ITU and for anaesthetics clinical representatives to plan a meeting with the radiology team to improve the reporting of incidental findings with the referral clinical team. Additional action points included sharing the investigation report findings with staff and with the patient. Senior leads told us a level of harm assessment had been completed for this patient given the patient had received several x-rays and computerised tomography (CT) scans where the guide wire could have been detected earlier.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2018 to May 2019. Both incidents took place at Queen’s Hospital. One was a medication incident and the other a pressure ulcer incident both meeting SI criteria. *(Source: Strategic Executive Information System (STEIS))*
Between 1 September 2018 and 31 August 2019, the CCU at King George Hospital reported 222 incidents of which one was categorised as moderate harm and one serious incident (never event involving the guide wire). The most common identified themes included tissue viability (43%), clinical care (15%), medication (10%) and workforce (10%).

Incidents were reported on the hospital electronic system. Staff were aware of their responsibilities for reporting incidents and able to explain how this was done. Staff members who reported an incident received individual feedback for incidents they had reported.

Key messages and lessons learnt from incidents were discussed with staff during handovers, ward meetings and weekly huddles. For example, learning from incidents was shared across both sites at the weekly quality and safety meetings which took place at Queen’s Hospital. We reviewed the minutes for September 2019 and found the learning from an incident was shared with a narrative on key events, factors contributing to care and areas for improvement. If staff were not present for meetings, they received emails to make them aware of the items discussed.

Staff were aware of their responsibilities in relation to the duty of candour. All staff we spoke with were aware of the principles of openness and accountability when things go wrong. Senior leads told us that mandatory training included duty of candour.

Senior leads told us morbidity and mortality meetings were incorporated into the weekly quality and safety meetings. Appropriate medical and nursing cover was arranged so that the ICU consultant and nurse in charge from King George Hospital could attend. Staff were able to travel between the hospital sites using a shuttle service. We reviewed the quality and safety meeting minutes for July 2019 and found each case included a narrative summary and learning points.

The trust policy required mortality checklists to be completed within 24 hours. We requested evidence of the checklist being completed. The trust provided data for critical care mortalities across both sites which showed that from 21 random reviews, 18 (85.7%) mortality checklists had been completed within 24 hours.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and three new catheter urinary tract infections from May 2018 to May 2019. *(Source: NHS Digital)*

We saw the Safety Thermometer data displayed on the quality of care board at the entrance to the CCU for staff and visitors. Data for August 2019 showed there had been no falls, pressure ulcers or unit acquired infections. Safety thermometer data between April and August 2019 showed the unit...
had reported zero pressure ulcers, urinary tract infections (UTI) and venous thromboembolisms (VTE).

We saw evidence that staff used appropriate risk assessments and care bundles to reduce the risk of patient harm. The unit had a comprehensive policy for the prevention and treatment of pressure ulcer which referenced the Braden scale. The primary aim of the Braden scale is to identify patients/clients who are at risk, as well as determining the degree of risk of developing a pressure ulcer. The scale is made up of six subscales, which measures elements of risk that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. These are: sensory perception, moisture, activity, mobility, friction, and shear.

A staff nurse was identified as the tissue viability link nurse on the unit and we saw that pressure-relieving equipment such as mattresses were readily available. We saw evidence of patient mobility assessment by physiotherapists and falls risk assessments completed for patients considered to be at risk. The four records we reviewed showed that venous thromboembolism (VTE) risk assessments had been completed.

### Is the service effective?

#### Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Policies and guidelines were kept on the intranet for staff to access. We reviewed a sample of policies and found that they appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges and were mostly in date. For example, the sedation guidelines for anaesthetists referenced the American Society of Anaesthesiologists (ASA) guidelines.

Policies were approved by the policy ratification group and staff were informed of new guidelines via the weekly huddles, emails or as an alert on the intranet for trust wide guidance/policy. However, we found that the paper version of the hand hygiene policy in hand hygiene folder was out of date (May 2013). We raised this with staff who removed the old policy and ensured the updated policy which expired in 2021, was placed in the folder. The updated policy referenced the World Health Organization (WHO) concepts of “5 moments for hand hygiene”, NICE guidance (CG139), Public Health England and Department of Health.

The unit also had intensive care unit (ICU) guidelines in the form of an ICU manual. We found the manual was detailed, informative and in date.

Staff delivered evidence-based care and treatment in line with The Faculty of Intensive Care Medicine (FICM) Core Standards for Intensive Care Units. We reviewed four patients’ healthcare records who were admitted to the unit during our inspection. We found that patients had their needs assessed and their care planned and delivered in line with evidence based, guidance, standards and best practice. For example, we saw that all patients were assessed for venous thromboembolism (VTE) and provided with VTE prophylaxis where required (NICE Quality Standard 3, 2018 and Guidelines for the Provision of Intensive Care Services, 2015).

The service also contributed and uploaded data regularly to the Intensive Care National Audit Research Centre (ICNARC), which provides information/feedback about the quality of care to those who work in critical care to allow service benchmarking against similar critical care units nationally.
The service actively engaged with the local critical care network to help support and improve delivery of high quality care. As members of the North East North Central London Adult Critical Care Network (NENCL), senior staff participated in regular meetings and shared feedback from these with staff.

The unit used care bundles. For example, the unit had a care bundle to prevent ventilator associated pneumonia. A care bundle is a group of evidence-based interventions, when performed together; improve outcomes more than if used individually.

FICM core standards state that all patients should be screened for delirium on admission to the unit. Staff told us that all sedated patients were screened for delirium by medical staff. We saw evidence of delirium screening in all the records we reviewed.

The trust had implemented a pain, agitation and delirium (PAD) protocol further to the findings of an audit in 2017. Medical staff used a ‘confusion assessment method’ (CAM-ICU) delirium tool to screen and manage patients experiencing delirium on the critical care unit and the Richmond Agitation-Sedation Scale to measure the agitation or sedation level of a person. The trust provided the re-audit results for May 2018 which demonstrated there had been a significant reduction in the incidence of pain, agitation and delirium following the implementation of the PAD protocol. Data showed 12.6% of patients were found to be in severe pain (previously 18.6%), 16.6% of patients were found to be agitated and inappropriately sedated (previously 34.8%) and 15.2% of patients were found to be experiencing delirium (previously 25.2%).

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

We saw that most patients had their nutrition and hydration needs regularly assessed and met in the records we reviewed. However, one of the records did not have the Malnutrition National Screening Tool (MUST) score on admission. All patients we checked were having their fluid balance and nutrition assessed hourly and an up-to-date nutrition and hydration care plan in place which was being followed.

Dieticians were involved in the assessment, implementation and management of appropriate nutrition support and completing nutrition plans. The dietetic team attended the unit to review patients on total parenteral nutrition (TPN), nasogastric (NG) feeding and nil by mouth patients and completed any follow-ups as needed. Staff could also refer patients to the dietetics team as needed.

We saw that patients who were unable to take food and fluid orally had their nutrition support (enteral or parental) commenced on admission where required, to ensure adequate nutrition to facilitate rehabilitation.

There were regular meals, drinks and snacks provided for patients who could eat and drink. One patient described the food as “simply delicious” and told us the water jugs were topped up daily.

The unit had a dedicated link nurse for nutrition and their contact details were seen on a notice in the staff room. Staff we spoke with could describe the hydration checks that took place 24 hours a day on patients for example, assessing fluid input versus output and checking for oedema. We observed that nutrition and hydration of patients was discussed in ward rounds.
Pain relief

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

Staff acted in a timely and compassionate way when patients experienced physical pain and discomfort. One patient indicated they were uncomfortable post-surgery and the nurse and doctor acted immediately to assess and resolve their discomfort whilst maintaining the patient’s privacy and dignity. The patient told us “the ICU care has been excellent”. We checked the patient’s record and saw there was an individualised pain relief plan in place.

Staff used a standardised tool to assess patient’s pain. The unit had a pain folder which showed the methods of verbal and non-verbal pain assessments and staff we spoke with demonstrated good awareness of them.

The trust had a nurse led pain team which included a specialist practitioner nurse, two clinical nurse specialists and two sisters. Staff were aware of the team and told us they could access this service Monday to Friday with anaesthetic consultant cover for evenings and weekends. This meant that if a patient required patient controlled analgesia (PCA) on the weekend, the ITU consultant or anaesthetist could initiate treatment. The unit had a dedicated link nurse for pain management which staff were aware of.

Patient outcomes

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

The trust has three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 annual report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

King George Hospital

The table below summarises performance at the Vanessa Woodward intensive care unit at King George Hospital in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non-clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>1.9%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>2.3%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) (Discharge from critical care should be within</td>
<td>0.4%</td>
<td>Not in the worst 5% of units</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
Audit results guide *(Source: Intensive Care National Audit Research Centre (ICNARC))*

The trust had working group for ICNARC data collection with dedicated nurses who had protected time of one day each week to collect data. The ICNARC auditor worked full time and checked the accuracy of the data. Senior leads told us that the nurses and consultants checked the coding on the wards before the data was entered and the senior team reviewed the data through validation reports to look for any gaps. Site specific ICNARC data was discussed at the quality and safety meetings and we saw evidence of this in the September 2019 minutes.

After the inspection, the trust provided current ICNARC data for April 2018 to March 2019. The quality care dashboard showed that the CCU performed within expected range for nine quality indicators (QI). These included: high-risk admissions from ward, high-risk sepsis admission from ward, non-clinical transfers to another unit, unit acquired infections in blood, out of hours discharge to the ward (not delayed), discharge direct to home, unplanned readmission within 48 hours, risk-adjusted acute hospital mortality and risk-adjusted acute hospital mortality (predicted risk <20%)

Senior leads told us the trust has worked with the clinical commissioning group (CCG) to review the coding for the ICNARC data and received good feedback around the accuracy of the data.

We received the trust’s CCOT activity report which showed the total number of referrals to the CCOT was 1943 between January and June 2019. The CCOT had completed 2831 assessments and provided advice on 66 occasions within the same reporting period.

The service monitored adherence to local best practice guidelines through a local audit programme. Senior leads told us junior doctors were involved in the audit programme and the trust had an audit lead who was based at Queens Hospital. The trust provided the 2019 audit programme for the CCU at King George Hospital which included “long-term outcomes after prolonged mechanical ventilation” and “renal replacement therapy practice”.

The trust provided the May 2018 benchmarking results for the North East North Central London Adult Critical Care Network (NENCL). From the 34 standards, the service met 20 standards and partially met seven. Although the service had not met the remaining seven standards, we found three of the standards related to pharmacy support which the service was addressing. The unit now had a dedicated pharmacist and the trust had completed a risk assessment on the pharmacy service provision. Although pharmacy staff were contracted for seven days, the trust recognised additional staff were needed to support weekend cover. The trust was developing a business case for this and had included developing a seven day pharmacy service as a local critical care priority for 2019-2021.
Although the trust had not been requested to undertake a re-audit recently, the critical care service used the previous results to identify areas of improvement. For example, the trust audited the time to consultant review following admission to the critical care unit (against the 12 hour standard). The audit reviewed 10 records for patients admitted between January 2019 and March 2019 and results showed nine patients had been reviewed within 12 hours by a consultant intensivist. The data and clinical audit action plan were presented at the departmental audit meeting with next steps to re-audit a larger sample of records.

**Competent staff**

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

From April 2018 to March 2019, 87.0% of staff within critical care department at the trust received an appraisal compared to a trust target of 90.0%. From April to June 2019, 25.4% of staff have received an appraisal.

The trust did not report any appraisal data for medical staff as part of the provider information request. We queried this with the trust and did not receive a response. After the inspection, the trust submitted data which showed the current compliance rates for medical staff was 60%.

**King George Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>2</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>1</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>28</td>
</tr>
<tr>
<td>All staff groups</td>
<td>31</td>
</tr>
</tbody>
</table>

**Trust wide qualified nursing staff working at both sites**

The trust reported appraisal data for qualified nursing staff, that work across both sites, under a separate trust wide section.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>9</td>
</tr>
</tbody>
</table>

However, please note that care should be taken when interpreting the rates which may be based on small eligible staff numbers. *(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

As of June 2019, the trust reported that 122 nursing staff had a post registration award in critical care nursing. Site breakdown can be seen below:

<table>
<thead>
<tr>
<th>Site/Location/Unit</th>
<th>Total number of nursing staff in unit (qualified)</th>
<th>Total number of nursing staff with post registration award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital ITU/HDU/SKY A</td>
<td>87</td>
<td>63</td>
</tr>
</tbody>
</table>
There were also 157 staff with training in specialised equipment. Site breakdown can be seen below:

<table>
<thead>
<tr>
<th>Site/Location/Unit</th>
<th>Total number of staff (qualified and unqualified)</th>
<th>Total staff with up to date training in specialised unit equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital ITU/HDU/SKY A</td>
<td>100</td>
<td>82</td>
</tr>
<tr>
<td>Queen’s Hospital neuro ITU</td>
<td>54</td>
<td>39</td>
</tr>
<tr>
<td>King George’s Hospital ITU</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Critical care outreach team</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)

Staff told us that learning needs were identified during appraisals and gave us examples where they were encouraged and given opportunities to develop subsequently such as leadership and mentorship courses. Staff were encouraged to complete the adult critical care course and told us they felt supported.

Staff rotated working across sites which facilitated exposure to different acuities and learning. Staff told us they could attend training days across sites. To address the education and development needs of staff, one of the band 7 nurses worked one day a week as the practice education lead for the unit. Senior leads told us junior staff received regular clinical supervision.

Senior leads told us that at every alternate week of the quality and safety meeting, there was a presentation for staff learning. A recent example of staff learning was on tissue viability. Key messages from these meetings were emailed to staff and discussed in nurses’ huddles.

The CCU had a practice development nurse (PDN) who worked closely with the PDNs in the critical care service in Queens Hospital to ensure the provision of a standardised structured education programme. The PDN delivered 11.5 hours of teaching days weekly and this included working clinically with staff and preparing and facilitating training and study days for the team. The PDN worked closely with specialist teams (such as stoma, tissue viability and pain) within the trust to provide up to date teaching sessions for staff. The PDN also provided support and guidance to the unit’s link nurses to ensure practice in their specialist areas remains current.

Agency staff received the critical care orientation pack with the induction programme checklist, orientation around the unit including equipment, covered key areas and the structure of the day. Agency nurses told us they received effective patient handovers and felt supported. New permanent nurses received the critical care nurse starters guide at their local induction and the national competency framework to complete in one year. Although the unit had no students at the time of inspection, the service had a separate ITU pack for students. New starters were assigned preceptors while they were supernumerary.

Doctors including locums received the trust’s local induction guide for anaesthetics and ITU and the anaesthetic doctor’s induction pack. The guide included information on team structures, clinical and educational supervisors, roles and responsibilities, security, useful contact numbers, trust policies, teaching and training, medical education structure and contacts and advice for self-learning for junior doctors. The guide also included a trainee’s feedback form which had to be completed within the first
two weeks of starting the post. In event the CCU at King George Hospital needed a locum doctor, a
trust doctor would be sent to cover the unit. The locum doctor would be sent to Queens Hospital as
this allowed them to work as part of a team of three doctors.

The service used the Steps Framework for Adult Critical Care Nurses developed by the Critical Care
National Network Nurses Leads Forum (CC3N) in collaboration with other professional critical care
nursing organisations and staff from Higher Education institutes. The CC3N are one of three forums
that represent the Critical Care Operational Delivery Networks, alongside the Network Medical Leads
and the Network Directors/ Managers.

Dedicated nursing staff were link nurses for the unit in a range of different areas and attended study
days to keep up to date with their relevant area.

The physiotherapy team worked across sites and completed rotations across respiratory, surgery
and the intensive care unit (ICU). Physiotherapy staff told us they were aligned to a senior
physiotherapist for support during their first on call and had the contact details for the team if
needed. Physiotherapy staff felt supported for their personal development and told us the clinical
lead for physiotherapy visited the site once a week to provide one to one supervision. The
physiotherapy team had weekly meetings which took place at each of the hospital sites in turn with
the option of video conference call to facilitate attendance. The agenda included sharing the learning
from any incidents, concerns and any staffing issues. Each hospital site had separate huddles to
help manage workloads effectively.

The therapy manager held monthly therapies meetings which were attended by dieticians,
physiotherapists and the Speech and Language Therapy (SALT) team.

The CCOT nurses received three months of supernumerary supervision with access to an intensive
care unit (ICU) consultant as a mentor. They also received support from the lead ICU doctor for the
outreach team and completed the advanced clinical practitioner qualification. The CCOT had regular
team meetings (approximately 10/12 per year) where discussions around recent issues and
incidents took place. The CCOT facilitated study days on haemodynamics and completed face to
face training with ward nurses. The CCOT also trained medical and nursing staff on sepsis and
organised two training sessions a month for nurses on the management of deteriorating patients.

Senior leads told us Health Education England (HEE) annual funding had reduced but the trust had
topped up the funds using the critical care budget for funding education for nurses. Medical and
nursing staff we spoke with across all levels told us that additional training opportunities were good.
We observed an “education” notice board which listed numerous study days available to nursing and
support staff. Junior staff told us the unit had a strong and supportive nursing team.

**Multidisciplinary working**

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

During our last inspection, we found little evidence of a multidisciplinary approach with access via a
referral basis. The exception to this was the physiotherapy team. However, on this inspection we
found improvements had been made. The unit had support from the critical care outreach team
(CCOT), physiotherapists, a dedicated pharmacist who visited daily and a volunteer who came to
help with administration tasks on a weekly basis.

The doctors ward rounds were held twice a day and attendance included the consultant, registrar on
day shift, registrar for night shift, physiotherapist, CCOT nurse, nurse in charge for the night and
nurse in charge for the day. We attended a ward round and found it to be very inclusive as the consultant discussed the plan for each patient with the multidisciplinary team (MDT) and encouraged all members to offer their comments or raise any queries.

We saw evidence of close working relationships between nurses and medical staff internally and externally. Nursing staff told us the medical staff were approachable and listened to their opinions whilst doctors said that input from nursing staff was invaluable.

The last inspection included an area of improvement we told the trust they should consider: to include a dietician as part of the critical care team. The trust had two whole time equivalent (WTE) critical care dieticians who worked across both hospital sites. This worked out to 0.05 WTE per bed at King George Hospital which was compliant with the British Dietetic Association’s recommendation of 0.05 to 0.1 WTE in the Core Standards for Intensive Care Units. Staff told us they could access the trust’s on site dietetics teams Monday to Friday 9am to 5pm. This complied with the FICM standard stating “critical care units must have access to dietitian five days a week during working hours”. The unit also had a dedicated link nurse for nutrition which staff were aware of. The physiotherapy team told us they worked closely with the dietetics team as they shared the same office on site.

There was a trust wide multidisciplinary team (MDT) meeting which took place weekly at Queen’s Hospital. Although the meeting was set up as a video meeting to facilitate attendance, the ITU consultant from King George Hospital attended in person. The meeting had representation from the physiotherapy and pharmacy team. Agenda items included showcasing good practice, sharing learning from incidents, raising concerns and discussing difficult patient cases.

During our inspection we observed the MDT ward rounds attended by the nurse in charge, ITU consultant, physiotherapist and the pharmacist. Each patient was discussed in turn outlining the next steps for investigation and the treatment plan.

Seven-day services
Most key services were available seven days a week to support timely patient care.

The service had a dedicated pharmacist who worked from 9am to 5pm Monday to Friday. On the weekends, pharmacy support was available 9am to 3pm on Saturday and 9am to 12.20pm on Sundays. Staff could access support from the on-call pharmacist and the site manager in the evenings and out of hours if needed. Staff told us emergency medicines were available in the emergency department. Both medical and nursing staff told us that pharmacy team were easily assessible to provide advise as needed.

The physiotherapy team included one part time band 7, one band 6, one band 5, two physiotherapy assistants and support from a band 7 from Queens Hospital for two days a week. The team was available Monday to Friday 8am to 4.30pm with on call cover in the evenings from 4.30pm to 8.30am. The on-call provision included two physiotherapists, one for each hospital site. Although the on-call physiotherapist was off site, they remained close to the sites as they were expected to come on site within one hour of being called if needed. On the weekends, the team would have a list of patients to see with the same on call cover for the evenings thereafter.

The trust’s infection prevention and control (IPC) team was available Monday to Friday 9am to 5pm with access to the duty nurse for queries. For evenings and weekends, staff could access support from the on call microbiologist.
The service accessed the Speech and Language Therapy (SALT) team via referrals for tracheostomy patients and staff told us the team were responsive. Although the unit did not have a dedicated dietician as part of the critical care team, staff could access support from the dietetics team on site. The dietetics team were available Monday to Friday 9am to 5pm. The trust told us there were plans to develop an on-call service for weekends to provide a seven day service provision. However, there were systems in place to ensure patients received nutritional care if they were at risk of malnutrition. Staff told us that they had protocols to follow if they needed to provide patients with enteral nutrition (tube feeding) out of hours and at weekends. If appropriate, medical staff could start the naso-gastric (NG) feeding regimen as soon as the patient was admitted to the unit. Then when the dietitian was available, they reviewed the patient and tailored the regimen to meet their individual needs. Staff had access to stocks of NG feeds on the ward in the pantry.

Emergency theatres were available seven days a week, 365 days per year and could be accessed following communication with the on-call anaesthetist. There was a theatre team on site 24 hours a day for this provision.

The radiology department provided computerized tomography (CT) scans and plain films x-rays Monday to Sunday from 8am to 8pm. Magnetic resonance imaging (MRI) scans were available Monday to Sunday 7.30am to midnight. Standby cover was available Monday to Sunday between 8pm and 8am by two radiographers and covered all general x-rays, theatres, mobile and CT cases. Staff told us that access to imaging such as angiography could be challenging on weekends whilst urgent CT scans were easily accessible.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The trust had a smoking cessation advisor in the hospital to support patients to stop smoking. The physiotherapy team told us they provided patients with advice on alcohol consumption and healthy lifestyle.

The trust’s occupational team provided data on the uptake of the flu jab in staff. The data showed that from 35 staff, 26 had received the flu jab, 3 had declined and 6 had not responded.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

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

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

Medical staff work across both sites. The trust did not report MCA/DoLS training completion rates for medical staff at site level. A breakdown of compliance for MCA/DoLS training courses from April to June 2019 at trust level for medical staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td>Trust level</td>
<td></td>
</tr>
</tbody>
</table>
Medical staff in critical care at trust level did not meet the target for MCA/DoLS training.

After the inspection, the trust submitted the current compliance rates for March 2019 to August 2019 for medical staff which showed the compliance rate for MCA and DoLS training was 84%.

**King George Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. A breakdown of compliance for MCA/DoLS training courses from April to June 2019 at King George Hospital for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td></td>
<td>30</td>
<td>30</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in critical care at King George Hospital all completed MCA/DOLS training.

**Trust wide nursing staff that work across both sites.**

The trust reported compliance for MCA/DoLS training courses for qualified nursing staff, working across both sites, under a separate trust wide section. A breakdown of compliance for MCA/DoLS training from April to June 2019 is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td></td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in critical care, working across both sites, all completed MCA/DoLS training. *(Source: Routine Provider Information Request (RPIR) – Training tab)*

There were trust policies in place for consent, the Mental Capacity Act (2005), DoLS, restraint and sedation. We reviewed each of the following policies and found they were up-to-date, where necessary reflective of legislation such as the Mental Capacity Act (2005) and Mental Health Act (1983) and the Mental Health Act Code of Practice.

Doctors completed mental capacity assessments with patients whose capacity to make decisions was in question. Specific capacity assessments were completed when key decisions about the patients’ care were needed and best interests’ decisions were made when the patient was unable to consent. We reviewed four sets of patients’ records and saw that appropriate consent forms were completed for all patients.

The trust told us compliance data for consent was not provided in the original provider information request as it was not mandatory training. Staff received local training during supervision and
induction sessions. The training included what patient information to provide, how to access the leaflets and keeping accurate records of consent discussions with patients.

**Is the service caring?**

**Compassionate care**

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

Patients and those close to them told us that staff were caring. One patient told us they were, “very happy with the care and that day and night attention had been fantastic”. Another patient told us, “yes staff are really kind and nice here.”

We observed good interaction by all grades of staff with patients and saw numerous examples which showed that staff took time to interact with patients and those close to them in a respectful and considerate manner. For example, one patient was intubated and woke up from sedation distressed, we observed staff members calm the patient straight away.

There was evidence that staff had established good relationships with patients and their relatives. Patients told us they had developed a good bond with the nurses and doctors. Patients described the staff as “exceptionally caring and compassionate”.

There were thank you cards to staff from patients and relatives displayed in abundance on a notice board at the entrance of the unit. Comments in these cards included: “you have all been amazing”, “Thank you very much for looking after me” and “We are grateful to you beyond measure and will always be, you are a credit to your profession”.

We saw that patient’s privacy and dignity was maintained whilst they were on the unit. Staff closed the curtains around the patient’s bed space before carrying out any personal care. Staff voices were kept low during ward rounds.

The NHS Friends and Family Test (FFT) was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feed back on their experiences of care and treatment. The trust provided FTT data derived from the ‘I Want Great Care’ (IWGC) database. Data showed that between February and April 2019, the average number of patients who were likely to recommend the service was 90%. Although the performance for May 2019 showed a reduction with the service achieving 69%, the service improved significantly between June and August 2019 reporting an average of 96%.

**Emotional support**

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

The unit used patient diaries which were funded by the hospital's charity. Patient diaries provide a daily record of each day’s event whilst a patient is in intensive care. Visitors were encouraged to fill in these diaries with information for their loved one when they wake up such as what’s been happening at home and what they had talked to the patient about. Staff also made entries in patient diaries with some details about the patient’s care and treatment. Supporting patients with a better understanding of what has happened to them in critical care may help to set realistic goals for

Patients who were approaching end of life on the critical care unit (CCU) were supported by the end of life care (EOLC) link nurse and the palliative care team on the unit if appropriate. If staff needed to deliver distressing news to relatives they were taken to a quiet room within the unit, away from patients and visitors where they could explain information and answer any questions they may have. All staff members had completed the EOLC course and the unit had a box with EOLC leaflets to give to families where needed.

The trust had site specific bereavement booklets which intended to offer reassurance, give suggestions about where to find help, information on some of the practical matters to be tackled, as well as advice on coping with the loss.

**Understanding and involvement of patients and those close to them**

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

Patients and their relatives told us that staff introduced themselves and gave them the opportunity to ask questions. We saw that where staff needed to move patients to make them more comfortable, they explained what they were doing and why and asked if the patient was ready. We noted that the reception desk was always staffed which meant relatives did not have to wait long for a nurse to let them in the unit.

We observed good interactions between staff on the ward round and patients on the unit. Patients and relatives were involved in discussions with staff during the ward round and were involved in making decisions about their care. Staff took their time to explain information about their diagnosis and care plans to patients and their relatives and to answer any questions they may have. We saw senior staff had a good understanding of all the patients on the unit and took the time to listen to patients’ concern and provide reassurance in a kind and caring way.

One patient told us the “staff supported the family too and took time to repeat information to them, so they didn’t have to”. The patient appreciated the support from the staff as they had decided to put a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) in place which was difficult for the family to accept. In the right circumstances, a DNACPR order helps ensure that a patient's death is dignified and peaceful.

Patients we spoke with felt they were kept informed about their care. One patient said they had “been kept informed about everything” and had been “made aware of the risks”. Comments in thank you cards included: “thank you for supporting my family, its true you are all angels of this world”, “I can’t fault my care” and “The care and attention was amazing, thank you for saving my life”.

The unit had a dedicated link nurse for EOLC and organ donation to explain the process of organ donation in a clear and supportive way to families as well as support other staff where needed. There were link nurses for stoma and tracheostomy who provided support for patients and staff in the unit.
Is the service responsive?

**Service delivery to meet the needs of local people**

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

The critical care unit (CCU) was an eight bedded unit providing care at level two (high dependency) and level three (intensive care) to adults who required a higher level of care than could be provided on the wards.

A dedicated critical care outreach team (CCOT) supported the unit. The CCOT were responsible for supporting staff with all aspects for the critically ill patient-pathway including early identification, tracheostomy patients and assessment of patients requiring admission to the unit. The CCOT provided educational support to enhance the skills and knowledge of ward staff in caring for at-risk and deteriorating patients in the general ward areas.

The unit was a member of the North East North Central London Critical Care Network (NENCL). The network was formed of lead health care professionals from 15 local critical care units with the aim of providing consistently safe, effective and coordinated care for patients.

Although visiting hours to the unit were standardised between 6am to 9am and 2pm to 7.30pm with two visitors only per bed space, staff told us that these hours were flexible dependent on people’s needs. For example, staff made exceptions for relatives of terminally ill patients to stay at their bedside.

The unit had two rooms for relatives to use. One room was outside the entrance to the unit and had seats, wash basin, fridge and television. The remote for the television was available from reception staff and there was a notice board for relatives which included information on communication and bringing in patient’s medications. However, some of the seats were damaged and required replacement. We raised this with senior leads who told us they were aware, and the chairs were included in the replacement programme.

The second relatives’ room was in a quieter area of the unit (within the anaesthetic offices) and was used to deliver bad news to relatives and patients. The room had a sofa bed, television and microwave so that relatives of acutely ill patients could stay overnight, where needed.

There were facilities within the hospital site where those close to patients could purchase hot food, snacks and drinks.

There was a ‘Good to talk’ notice board at the entrance of the unit with information on the telephone translation service, raising communication needs for learning disability/hearing loss and visual impairment, chaplaincy (available 24 hrs per day) and Patients Advice Liaisons Service (PALS).

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The trust’s chaplaincy team provided spiritual, pastoral and religious support to patients, visitors and staff across the trust and was available for everyone, whether a religious belief was held or not. The service was available 24 hours per day, seven days per week. The chaplaincy team included chaplains from Christian and other faith backgrounds through established links within the local faith...
communities including: Jewish, Muslim, Hindu and Sikh. The hospital had a multi-faith prayer room on site where people could sit quietly or pray privately. These rooms were open for patients, visitors and staff to use, whatever their beliefs may be. Staff told us families and relatives could access support from the bereavement counsellor where needed.

The trust had suitable arrangements in place for people who needed translation and advocacy services. Staff had access to a telephone-based translation service where English was not their first language. We also saw notices advertising translation services in public areas.

The service met the cultural and religious needs for meal preferences. For example, patients could order Halal or Kosher food. Parents told us they were happy with the lunch menu and choices. We saw that different textured food was also available.

Although the unit had limited information in different languages, we saw a ‘wash your hands’ sign displayed on the side room door in 24 different languages which included Swahili, Spanish, Thai, French, Hindi, Korean, German.

The trust had individualised ‘hospital passports’ for patients with learning difficulties. The passport was a communication book which included details such as the likes and dislikes, their interests and favourite items. This information helped staff understand the patient and make them more comfortable. Each bedside displayed the name of the doctor, nurse and student for the patient. Staff could access support from the trust’s learning disability liaison nurse team who were available Monday to Friday 9am to 5pm and worked across both sites.

The unit had dedicated link nurses within the critical care team for several areas and their contract details were on the staff notice board. The unit had link nurses for learning disability, dementia, infection prevention and control, stoma, medicine, blood transfusion, tracheostomy, naso-gastric tube insertion, pain and medicines management.

Although there was no dedicated psychological support service for the unit, staff told us they could access the mental health liaison in the emergency department for support. The hospital’s emergency department could refer patients to the psychiatric liaison service who worked with the hospital to ensure that physical health needs were addressed, and mental health assessments were carried out in a timely way. The psychiatric liaison team signposted patients to services or referred patients to appropriate services in primary or community care. The team also provided training and advice to acute hospital staff to enable them to better support and understand the needs of mental health patients. The team was available Monday to Friday 9am to 5pm. Staff told us the CCU had close working links with the local mental health hospital.

Access and flow

The critical care unit was making gradual improvements to ensure the service admitted, treated and discharged patients in line with national standards.

From June 2018 to April 2019, Barking, Havering and Redbridge University Hospitals NHS Trust had a similar adult bed occupancy level to the England average for 10 out of 12 months.

Adult critical care Bed occupancy rates, Barking, Havering and Redbridge University Hospitals NHS Trust.
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. *(Source: NHS England)*

The CCU had eight beds and staff told us there would usually be six level 3 and two level 2 patients with flexibility if needed. Patients were admitted to the unit through the emergency department, the acute medical unit after surgical procedures and from wards where the patient was identified as deteriorating and requiring high dependence or critical care. Occasionally, patients were transferred from Queens Hospital. Senior leads told us that cancellations of elective surgery was an issue that affected patient flow at the hospital. Between August 2018 and August 2019 there were 632 admissions to the CCU.

Staff appropriately escalated mixed sex breaches in a timely manner to the lead nurse which would then be escalated to the triumvirate team and the executive team. Bed meetings took place three times a day and attendance included members of the executive team, bed manager, allied health professionals, pharmacy, pathology and the site manager. Representation from each division was mandatory at each bed meeting. Senior leads told us there would be dedicated staff member at the bed meeting to champion for critical care capacity and mixed sex breaches. After the inspection, the trust confirmed that in the last 12 months, there had been no mixed sex breaches at King George Hospital CCU.

Where patients had to be transferred to another hospital; for example, neuro patients to Queens Hospital, staff told us they would check if it was safe to transfer the patient first. Staff completed the transfer checklist, discharge summary and booked the transport. Level 3 patients would be accompanied by an ICU doctor and nurse. At times where the unit had bed capacity issues, staff told us stable patients were transferred to Queens Hospital and unstable patients remained on site.

The Faculty of Intensive Care Medicine (FICM) core standards for intensive care units’ states that discharge from intensive care to a general ward should occur within four hours of the decision being made. Patients must be moved to a more suitable environment without unnecessary delay and there should not be a non-clinical reason preventing such a move. The trust provided data for the number and percentage of delayed discharges where patients waited over four hours. The data for King George Hospital showed gradual improvements in performance. For example, in February 2019, the number of delays was 31 (51%) and this had reduced to 20 (38%) in August 2019. Staff told us that stepping down patients was difficult leading to delayed discharges and admission.

The trust provided audit data which looked at the time taken from decision to admit to the critical care unit. The audit reviewed 80% of the 597 admissions between September 2018 and August 2019. The decision to admit (DTA) time was between 75 minutes to 250 minutes. The audit conclusions noted the results were not in line with expectations and the exact DTA was not recorded frequently. The audit included recommendations to improve data collection with plans to re-audit in April 2020.
During the last inspection staff told us some patients were cared for overnight in the theatre recovery area with appropriate staffing, if there was no bed available on the unit. On this inspection staff told us this practice was no longer happening. After the inspection, the trust confirmed that in the last 12 months, there had been one occasion where a patient had stayed overnight due to unavailability of ITU/HDU beds.

The service used the Red2Green approach to facilitate patient flow in the hospital. The Red2Green approach is a visual management system which identifies the wasted time in a patient’s journey and helps reduce internal and external delays as part of the SAFER patient flow bundle. SAFER is a practical tool to reduce delays for patients in adult inpatient wards.

The critical care outreach team (CCOT) delivered nurse-led clinics reviewing approximately 16 patients per month. The team used a questionnaire to help identify any physical issues and wrote to the patient’s general practitioner (GP). The CCOT had follow up clinics twice a month where up to 14 patients were reviewed each month.

Although the trust did not carry out any audits on attendance or outcomes of follow-up clinics, the service monitored patient outcomes. For example, the service invited patients to attend a follow up clinic if they had been intubated and ventilated for more than 48 to 72 hours or had been an inpatient in critical care for five days or more. In the last 12 months, 141 patients from across both sites qualified for a follow up clinic. Of these, 79 patients (56%) attended the clinic and 63 were discharged and 16 were given new appointments for further checks. Where issues were identified, letters were either sent to the patient’s GP or in some cases, referrals were made directly to the appropriate service such as physiotherapy. For the 62 patients (44%) who did not attend the initial appointment, they were contacted to discuss their absence and offered a new appointment if they were willing to attend.

The trust had reviewed the end of life care (EOLC) care plan and implemented a 24 hour critical care EOLC care plan. The care plan was signed off by the doctor and staff would then work on the plan for 24 hours after which, the patient would be discharged to the ward.

We asked the trust to provide audit data alongside a standard operating procedure (SOP) to evidence that consultant’s out of hours response times were in line with FICM core standards. The trust did not provide this as they did not currently monitor this with a SOP. However, the trust told us they would review this as part of the critical care audit programme.

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

The unit displayed contact details for the Patients Advice Liaisons Service (PALS) at the entrance of the unit and had a concerns and complaints leaflet which included information for patients on what to expect once they make a complaint. The leaflet included information on the PALS team, the independent health complaints advocacy service (IHCAS), the parliamentary and health service ombudsman (PHSO) and contact details for the complaints team.

The patients we spoke with had awareness on how to make a complaint. The service discussed complaints in the weekly quality and safety meeting to ensure appropriate actions were taken. Staff told us that complaints were also discussed at the weekly nurses’ huddle to share any learning.
King George Hospital

From April 2018 to March 2019 there were three complaints about critical care at King George Hospital. The trust took an average of 22.0 days to investigate and close complaints, this was in line with their complaints policy, which stated complaints should be answered within 25 days. A breakdown of complaints by type is below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From May 2018 to April 2019 there was one compliment about critical care (at Queen’s Hospital). (Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

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

Staff we spoke with told us leaders were supportive and approachable, and felt their concerns were listened to.

The critical care service was part of the anaesthetics division which also included surgery. The anaesthetics division was led by a divisional director of nursing, medical director and a divisional manager who covered both anaesthetics and surgery. Staff demonstrated awareness of the triumvirate team and described them as visible. Although the divisional team was based at Queens, staff told us they visited the unit once a week. There was a lead nurse (sometimes referred to as matron) for critical care across both sites. The lead nurse visited the unit twice a week and staff told us they were more visible than the previous lead nurse.

Both nursing and medical staff of all grades spoke of good teamwork within the service. Staff told us that there were opportunities to develop, and leadership training was offered within the trust.

Vision and strategy

Although there was no formalised vision and strategy for the critical care service, the trust’s work on developing their strategic plans to meet the requirements of the local healthcare sector was ongoing. However, the trust had local strategic priorities for 2019 to 2021 which had been developed in response to the North East North Central London Adult Critical Care Network peer review and the Getting It Right First Time (GIRFT) programme. The GIRFT programme helped to improve the quality of care within the NHS by bringing efficiencies and improvements. Senior leads demonstrated awareness of the service’s risk register, explained what the services priorities were, and that necessary action was being taken to achieve these.
Senior leads told us their vision for the critical care service was to have less silo working and be one team including the critical care outreach team. The senior leadership team planned to continue with the recruitment and retention campaign, in addition to striving for nursing and clinical excellence. Senior leads wanted all staff members to have equal chance to contribute as they recognised the service had talented band 5s.

Although the service had capacity challenges, senior leads told us discussions were taking place around opening a four bedded unit for level 1/1.5 on the hospital site. Separate discussions were taking place on moving the surgical beds closer to the critical care unit to improve patient flow, but the challenge logistically would be ward swapping.

Although staff demonstrated awareness of the trust values (PRIDE), we did not see the values displayed on the critical care unit. Staff told us that quality and safety was a top priority in terms of service vision and aims.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt supported by their managers and colleagues. They said it was a friendly team and they felt listened to if they raised concerns. Staff described the unit as “a happy unit”. The staff room displayed photos of the team social nights out.

Senior leads were proud of their established team and told us staff were dedicated. Staff described the environment as supportive to newly qualified staff with good team work ethic.

Staff spoke positively about the ‘star of the month awards’ where staff members voted for each other. Recipients were notified and received a certificate, chocolate and a pen.

The trust had equality and diversity forums such as the lesbian, gay, bisexual, and transgender (LGBT) awareness forum and a learning disability forum.

The trust had provisions to optimise physical wellbeing of staff which was displayed on the staff notice boards in the unit. For example, there was information on exercise classes, yoga, relaxation classes and massages.

Staff had access to freedom to speak up guardians and multi faith support. Although the intranet had information on freedom to speak up guardians, we found staff had inconsistent awareness of them.

The trust provided occupational health services for staff. The team included occupational health doctors, specialist nurse practitioners, occupational health advisors, physiotherapists, psychologists and health and well being advisors. The trust had been accredited by the Safe, Effective, and Quality Occupational Health Service (SEQOHS) since 2015. Health and wellbeing for staff included sports and exercise (such as yoga and pilates); pampering and complimentary therapies (such as massages and reflexology) and motivational and healthy events (such as walk or cycle to work). Staff could also receive links to mental health therapies and the employee assistance programme.

Senior leads told us it was important for them that staff members felt valued and respected. For example, the staff room displayed positive staff feedback on valuing each other with ‘staff shout outs.’ Sticky notes were used to write compliments for staff members who had been helpful or was doing a fantastic job.
There were processes in place to support staff during challenging circumstances. Staff told us they had access to debriefing sessions to facilitate reflective practice and speak about how they were feeling. Senior leads told us the unit was “very close like a family so getting staff to talk about their feelings wasn't difficult”.

**Governance**

**Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

There was clear governance structure for the service and staff at all levels were clear about their roles and understood their responsibilities. Weekly quality and safety meetings took place at Queens Hospital to discuss the critical care service across both sites. The meetings had a multidisciplinary attendance which included doctors, physiotherapists, pharmacists and nurses. Although all staff were welcome to attend, staff told us the manager for the CCU at King George Hospital attended and conveyed key messages to all staff thereafter. We reviewed three sets of minutes for July, August and September 2019. Although the minutes showed the meetings were well attended, the minutes only included the number of attendees and no list of names. This meant it was not possible to see what representation of staff were from King George Hospital.

The divisional quality and safety meetings took place monthly and were attended by the triumvirate team, deputy managers, clinical lead, the relevant leads for each area, general manager, the quality and safety lead and patient partners. The divisional director of nursing chaired the meetings and each speciality reported by exception. We reviewed the minutes for June, July and August 2019 and saw the meetings had a standardised agenda and representation from each hospital site. The meeting included discussion on actions from the previous meeting, outstanding risks, serious incidents, staff rota, safeguarding, infection prevention and control, vacancies, complaints, education and patient feedback. Action plans included named leads, completion dates and status. Data metrics were site specific; for example, data on staff vacancy and ICNARC was by site level. The divisional quality and safety meetings reported into the patient safety group where each division produced a monthly report.

Senior leads told us escalated items reported into the quality and governance steering group which was attended by the divisional director for nursing. The steering group would then report up to the quality and assurance committee (QAC) meetings which were chaired by the non-executive team.

The triumvirate for the critical care service and executive team had monthly meetings to review the divisional performance. We reviewed the divisional performance review meeting minutes for May 2019 where the divisions performance for April 2019 was discussed. The action log included outcomes, the named lead, the name of the committee monitoring delivery and the expected completion date. The meeting included discussion on the top risks for the division, patient experience and feedback, incidents, ward scorecards, leadership and improvement (including people and culture) and core skills training.

As staff worked across both hospital sites in the trust, senior leads organised meetings on each site on a rotational basis where possible, to facilitate attendance. For example, the trust’s lead nurse for critical care held bi-monthly band 7 sister’s meetings as a forum to discuss the critical care service, to share any issues or concerns and to make decisions as a group. We reviewed the minutes for March, May and July 2019 and found there was a list of attendees and apologies. We found there
was consistency in the format and structure of these meetings with discussions on staffing, annual leave and any concerns on the wards.

The lead nurse had weekly meeting with the senior nurses for each area for both sites. We reviewed the minutes for August and September 2019 and found discussions on each area took place. The senior nurse from King George Hospital either attended in person or phoned in.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Senior leads and managers of the critical care service had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. We reviewed the trust’s anaesthetic division report for June 2019 which reviewed the divisional risk register for the critical care service. We found that risks identified on inspection were on the risk register, including staffing, mixed sex breaches and capacity.

We discussed mixed sex breaches with the senior leadership team who told us that as soon as the patient was stepped down to go to the ward, the consultant was informed. There would be a multidisciplinary approach to discuss the necessary safety mitigations and for decision making. Exception reports were completed monthly and included details on safety mitigations and step downs for each breach. Senior leads told us that infection prevention and control with appropriate isolation would be prioritised over privacy and dignity. After the inspection, the trust confirmed that in the last 12 months, there had been no mixed sex breaches at King George Hospital CCU.

Although the risk register included both medical and nurse staffing and capacity, the risks were documented against Queens Hospital. The senior leadership team informed us that nine international nurses were due to start in December 2019 in addition to the newly qualified due to start soon. The trust planned to keep the focus on recruitment and retention and had recently implemented a preceptorship programme in September 2019. The aim of the programme was to increase practice education support for new starters to help improve retention. The trust had a tight rota control for medical staff and had recruited junior doctors through word-of-mouth recommendations. The trust provided the current risk register for September 2019 which showed the CCU at King George Hospital had no risks documented.

Although staff were aware that the trust had a major incident plan policy, they were not always able to articulate what was included in it. We reviewed the policy and found it to be up to date and comprehensive. For example, the policy included a response activation flowchart, outlined roles and responsibilities and had appendices which listed an internal and external contacts directory.

Senior leads had started discussions on how to manage the challenges for the coming winter. The senior leadership team planned to promote flu vaccinations amongst staff, maintain the drive for the retention and recruitment campaigns and effectively manage staff leave.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
Although computer stations were available so that staff could access the intranet and internet on the unit, staff told us they would benefit from additional computer on wheels on the unit. Staff were aware of how to use and store confidential information.

The staff notice boards displayed a range of information which included: upcoming training such as conflict resolution, employee assistance programme (which provided confidential counselling) and information on exercise classes such as yoga and massage. Other information included contact details for the link nurses, speech and language therapy (SALT) team, intensive care unit (ICU) registrar, nursing education support and link lecturers for students. The unit also had notice boards on end of life care (EOLC) and creating a caring culture.

The unit displayed a notice called ‘Big 4 for the week’ behind reception which highlighted key messages for staff from the weekly huddles. For example, the current notice included communication messages from the pharmacy team.

Staff told us the intranet was slow at times and we observed this ourselves when we searched the intranet for trust guidelines.

We did not see the trust’s values (PRIDE) displayed on the critical care unit. We discussed this with senior leads who told us there were aware of this and had plans to use the reception area to display more trust posters.

Staff told us the unit used a social media platform on their mobiles to stay in touch with each other.

**Engagement**

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

During the last inspection, the trust was advised that it should consider ways to engage patients in providing feedback specifically related to critical care services. On this inspection, we found improvements had been made as the service used the trust’s ‘I want great care’ database to provide internal information on critical care services.

The trust had a patient experience strategy which aimed to enable and empower all staff within the trust to feel able to put patient experience at the heart of everything they do. The trust’s patient experience team had developed the patient story tool within the trust. Patient stories were heard at every corporate welcome to reinforce the power of patient experiences to all new colleagues. Patient and staff stories were heard at bi-monthly trust board meetings.

The service listened to patient feedback and made improvements as needed. For example, some patients had said the unit was too noisy at night. Staff provided patients with sleep well packs which included eye masks and ear plugs. The service was also looking to improve the doors and bins to make them soft closing.

The lead nurse appreciated her team and wanted to ensure they had work life balance. Senior leads described the team as “less unsettled”.

Although the trust provided the summary of actions for the 2018 staff survey, the actions were not site specific which meant it was difficult to ascertain which action point was applicable to King George Hospital. The anaesthetics division had three actions under communication and engagement, one action for safety at work and one action for bullying and harassment. Staff we
spoke with told us they had not witnessed any bullying or harassment in the department. Some staff commented that the team was like a “small family” and they prided themselves on good teamwork.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The trust was in the process of launching development and innovation groups (DIGs) further to staff feedback received. Key topics included pain/sedation, patient experience, renal, sepsis, wellbeing, tissue viability, end of life care (EOLC), documentation, diabetes, infection prevention and control (IPC), medicines management and nutrition. Each DIG would have a lead from each hospital site, adopting a multidisciplinary team approach and working collaboratively with the other site. The objective for each DIG would be to look at the relevant education for the topic and update any related policy or guidance where needed. Senior leads recognised that time was the biggest challenge to attract volunteers but felt DIGs were important for staff development. Senior leads told us the DIGs would have terms of reference in place for consistency and would feed into the weekly quality and safety meeting.

As part of the trust's commitment to addressing the staffing challenges, the trust introduced research posts four months ago, which were 50% clinical (based at King George Hospital) and 50% research (with the research consultant based in Queens Hospital).

In October 2018, the trust's critical care nursing team were finalists in the Emergency and Critical Care category: ‘A holistic approach to patient experience in critical care’.

King George Hospital

End of life care

Facts and data about this service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

Macmillan specialists also support the trust and provide a palliative care team and the trust has an end of life care team (EOLC). Both teams work across both hospital sites across all settings. There are no inpatient palliative care beds.

There is a seven day a week face to face palliative care support for patients and staff and 24-hour telephone advice available from a consultant in palliative medicine. The trust use an individualised end of life care plan to tailor care in the last few days or hours of life. The trust also use the gold standards framework (GSF) to identify patients who may be in the last year of life. The GSF is in use in care of the elderly, renal, haematology, and oncology wards.

The trust reported they collect data to track progress against key strategic objectives and feedback from carers collected through the bereavement survey and complaints monitoring process. Data is fed-back to frontline staff to improve care.
End of life care was delivered on most wards at King George’s Hospital, by ward staff who were supported by specialist multidisciplinary input. There is a specialist palliative care team (SPCT) and an end of life care team who provide care, advice and support in the delivery of direct patient care across the hospital.

In 2018/19 a total of 2214 patients died at both of the trust’s acute hospitals (King George’s and Queen’s Hospital). 1723 patients who were known to the specialist palliative care team died during 2018/19. Therefore 78% of deaths at the trust were seen by the specialist palliative care team. A total of 2082 patients were referred to the specialist palliative care team over the same period: 918 non-malignant disease, 995 malignant disease, 6091 face to face visits, 2440 episodes of telephone advice and 75 patients seen in outpatients.

The specialist palliative care team was comprised of palliative consultants, clinical nurse specialists, a social worker, discharge coordinator, team administrator and an occupational therapist. There were also end of life care facilitators and an end of life care consultant. They were supported by a team of chaplains and pastoral visitors. The role of the team includes assessment and care planning for patients with complex palliative care needs, treatment, medication, symptom control and emotional and psychological support for patients and their relatives and loved ones.

We were not able to speak with patients and relatives. We did encounter patients at the end of life and some of their relatives. However, it was not possible to speak with them because some declined and some patients were not well enough to speak with. We did review the results of the bereavement survey, competed by relatives 12 weeks after the death of their loved ones, which asked them about theirs and their relative’s experience of care. We also read several cards that had been sent to wards by relatives that related to end of life care. We observed care and treatment within the wards and reviewed 23 care records that included 17 Do Not Attempt Cardio-Pulmonary Resuscitation forms.

We also spoke with 22 members of staff, which included ward managers, nurses and healthcare assistants, ward doctors and specialist support staff such as occupational and physiotherapy staff. We also spoke with senior managers, porters, mortuary staff, chaplaincy, bereavement coordinators and all members of the specialist palliative care team, end of life care team and senior trust managers.

Is the service safe?

Mandatory training

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

The trust set a target of 90% for completion of mandatory training except for the information governance module which had a 95% target. Data was provided against the trust rather than at a specific site level.

A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>12</td>
</tr>
<tr>
<td>Information governance</td>
<td>13</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>13</td>
</tr>
<tr>
<td>Fire safety</td>
<td>13</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>1</td>
</tr>
<tr>
<td>Health, safety and welfare</td>
<td>13</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>13</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non touch technique (ANTT)</td>
<td>13</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>13</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>13</td>
</tr>
<tr>
<td>Equality, diversity and human rights</td>
<td>12</td>
</tr>
</tbody>
</table>

In end of life care the 90% and 95% target was met for all 11 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>8</td>
</tr>
<tr>
<td>Moving and handling level 1</td>
<td>9</td>
</tr>
<tr>
<td>Equality, diversity and human rights</td>
<td>9</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non touch technique (ANTT)</td>
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<td>8</td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
</tr>
<tr>
<td>Fire safety</td>
<td>7</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>7</td>
</tr>
</tbody>
</table>

In end of life care the 90% and 95% target was met for four of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

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

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>12</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for both of safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding adults’ level 2</td>
<td>8</td>
</tr>
</tbody>
</table>

In end of life care the 90% target was met for none of the two safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We spoke with six members of ward staff who were all aware of safeguarding, knew how to access the safeguarding leads and were able to give examples of when safeguarding would be required. We spoke with clinical nurse specialists (CNS) and occupational therapists from a variety of teams supporting end of life patients. They were knowledgeable of safeguarding including the types of incidents that might trigger a referral and who the leads were and how to contact the safeguarding team.

We observed wallcharts on wards with the local safeguarding team structure that included board level responsibility along with adult, child and midwifery safeguarding leads.

All specialist palliative care team (SPCT) and end of life care (EOLC) team staff received safeguarding training as part of mandatory training which involved both e-learning and face to face. Senior SPCT staff told us that safeguarding came up frequently in their work and the team had a close working relationship with the trust safeguarding team within the hospital. The team also referred to the community safeguarding team as necessary, which would usually follow ward visits where holistic assessments had taken place. Safeguarding issues were often discussed with families prior to referral.

**Cleanliness, infection control and hygiene**

**Staff used infection control measures when visiting patients on wards and transporting patients after death.**

We saw evidence that equipment and clinical areas were clean and well maintained. Wards were visibly clean and hygienic. Staff told us there were daily infection prevention surveillance rounds with the current focus on flu and diarrhoea. There were ample cleansing stations. We visited all areas of the hospital that provided end of life care to patients and their families. We saw green ‘I am clean’ stickers used throughout the Cedar Centre hub. Cleaning schedules were in place and being followed.

The mortuary was visibly clean and free from odours. It was cleaned on a daily basis and the floors were machine cleaned weekly. The cleaning of the fridge area was the responsibility of the mortuary staff and was also visibly clean and free from odours. Porters were responsible for wiping down concealment trolleys after use with sporicidal wipes.
Environment and equipment

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

The trust used the McKinley T34 syringe driver, the stock of which were kept by the specialist palliative care team (SPCT). Some wards with high use retained one for ease of access and additional ones were obtained from the SPCT. There was provision of syringe drivers out of hours via bed managers. For patients discharged home with syringe drivers, a paper trail was provided by the SPCT who also provided a padded postal bag to post the driver back. The SPCT stated that this process worked well but involved chasing the community teams to achieve return. The syringe drivers were serviced annually, and we clearly observed the date of next service clearly labelled on the drivers we saw, which were within service date. Ward staff told us that access to syringe drivers was good including out of hours access. Also, that the SPCT nurses were helpful if there were any difficulties.

Ward staff told us they had no issues relating to the availability of equipment needed to provide care for patients at the end of life. Nursing staff told us there was good access to pressure relieving equipment, usually within the hour, with a three hours maximum wait. The discharge facilitator from the end of life care team organised equipment for end of life care patients returning home along with the occupational therapist. We were told that hospital beds for use at home were ordered by the district nursing teams who were employed by another trust. All other equipment relied on varying processes depending on which local authority patients were returning to. This was worked with by the discharge coordinator and occupational therapist having a good knowledge of each borough’s processes, good channels of communication and referrals being made as early as possible. However, even then, some district nursing teams were reported as not ordering a bed until discharge had been confirmed. The SPCT had a stock of equipment to assist with discharges such as slide sheets and commodes which were used in emergencies to assist in achieving rapid discharge. Any issues that related to access to equipment for the home were related to community partners and were difficult to mitigate beyond what was already in place.

In the mortuary there were 36 fridge spaces and four bariatric spaces. There were no deep freeze spaces. If this was required, people would be transferred to the trust’s other mortuary at Queens Hospital or to the local undertakers if storage was required. The trust had a contract with a local undertaker when extra capacity was needed. Capacity was calculated in advance such as before weekends and winter periods. Capacity was described as usually enough. For instance, in the last year, six people were moved to Queens Hospital due to capacity. No post mortems took place at the mortuary, which was not licensed or regulated by the Human Tissue Authority.

The mortuary and fridges at KGH were managed by trust estates. Mortuary fridges were serviced shortly before our inspection as part of an annual service. Any issues were reported through estates who addressed any maintenance issues. We were told there had been no fridge breakdowns in three and a half years since the mortuary manager had been in post. Any breakdown or any temperature variation that was outside of normal range, was not linked to an alert system. This meant that any out of hours breakdown relied upon the porters hearing an audible alarm. The porters were based next door. This had been risk assessed and reported through the divisional quality report. We were told upgrading was being costed, but at the present time, there were no firm plans to change this.

Vehicular access was via an exclusive entrance, accessed through the trust goods yard, secured by barrier entry.
Personal protective equipment was used by the porters on the ward and in the mortuary and removed while transferring deceased people between the two. There were two concealment trolleys for transportation of deceased patients to the mortuary. Trolleys had a shelf underneath to hold patient notes. Covers were adorned with the daisy symbol for dignity. The ‘X cube’ was a frame that went over the concealment trolley and used for transporting bariatric patients to the mortuary. It was broken at the time of our visit. We were told that the mortuary lead had come in on Monday morning to find this broken and was to be rapidly replaced.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

We observed the SPCT morning handover meeting. The team joined their SPCT trust colleagues at Queens Hospital by teleconference for a joint meeting. All patients on the caseload were discussed. Patients were triaged during handover and daily work was allocated to appropriate team members. Patients were triaged as red; highly complex, amber; complex but stable, green; stable and nearing discharge, blue; fast track discharge. The meeting covered the risks and individual needs of patients. For instance, discharge planning, complex symptom control, requiring urgent review and multidisciplinary working alongside other teams such as the lung multidisciplinary team (MDT). There were family needs being discussed and a flexible working approach was evidenced by the SPCT to meet patient need. Although succinct, the handover meeting was highly effective. The team had 42 patients on their caseload trust wide, who were all discussed in the morning handover meeting. 13 were patients at King George’s and 29 patients of Queens Hospital. We were told this was an average split in referrals.

We observed patient review with a CNS from the SPCT. The patient was in the last days of life and had been identified as dying the day before. They had been moved to a side room for privacy and dignity. Symptoms were reviewed to assess comfort. The drug chart was reviewed to ensure anticipatory medications had been prescribed, which they had. The daisy symbol (patients for end of life care are identified with a gerbera (daisy) symbol) was in use to identify the patient to staff, for sensitivity when interacting with them and their family. We spoke with the ward consultant caring for the patient. They told us the SPCT were available in supporting end of life care. They were also planning a joint review meeting with a SPCT consultant and the patient’s family and identified complex family issues. They told us the SPCT were always available and provided valuable support and help with complex cases.

Board rounds took place twice a day at 9am and 2pm. Where appropriate, GSF coding was reviewed at both meetings and actions agreed, indicated by a daisy symbol on the board. For green coded GSF, nursing staff often commenced discussions with families about advanced care planning, but generally we were told, it was an MDT approach. For patients coded as amber, discussions were usually led by the registrar or the consultant and quite often involved a fast track discharge. The EOLC facilitators and SPCT supported with decision making including the palliative care consultant for more challenging decisions and discussions with patients and families. We spoke with members of the ward and multidisciplinary teams. Staff told us they felt confident in recognising patients at the end of life and believed that introduction of the Gold Standard Framework (GSF) had improved the recognition of dying patients and the need for end of life care.
We observed a 9am board meeting in relation to end of life care on Fern ward. The meeting was well attended by the multidisciplinary team including consultants, occupational therapy, physiotherapy, nursing staff and an EOLC facilitator. There was a good level of participation from all multidisciplinary team (MDT) members and a good level of challenge. Staff clearly felt comfortable to express their views and concerns. The discussions were respectful, patient centred, and staff listened to each other. Gold Standards Framework (GSF) grading was reviewed for patients, with changes and actions agreed. There was discussion and identification of patients requiring fast track discharge arrangements. There was identification of patients requiring the involvement of the SPCT and involvement and discussion around cancer MDT outcomes and decision making. There was identification for patients requiring involvement of a SPCT CNS for syringe driver need. There was consideration and discussion of family and care need and a good knowledge and awareness of patients’ home and care circumstances. There was discussion on complex Proactive EnhAnced CarE (PEACE) plans and managing patient and family expectations. The PEACE plan was designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP.

The individualised end of life care plan (IEOLC plan) allowed for the achievements of the five priorities for care. These included recognition of dying, sensitive communication, shared decision making, needs of families and a care plan that included food and drink, symptom control, psychological, social and spiritual care. We reviewed IEOLC plans and found the plans had been completed to a good standard. A review of the daily comfort rounds showed that patients were having assessments of essential needs that included assessment of pain, nutrition, hydration, mouthcare at least every two hours. Actions related to comfort rounds and additional care was recorded clearly in the daily additional information rounds. The end of life care facilitators reviewed all IEOLC plans including the quality and completeness of data, which was collated and sent to each ward. A recent initiative was that ward leads had to respond with an action plan indicating how improvements could be made. Education and training were provided by the EOLC facilitators to help wards to achieve improvements in outcomes of action plans.

**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target All staff</td>
<td>31.3</td>
<td>4%</td>
<td>0%</td>
<td>17.4%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12.0</td>
<td>0%</td>
<td>0%</td>
<td>21.0%</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

There were six clinical nurse specialists (CNSs) in the SPCT plus a manager who all worked across the two acute hospital sites of the trust. The end of life care team had three end of life facilitators who were all band 7 nurses who also worked across both hospital sites. Funding had recently been created for a band 6 development post to free up a second CNS to cover weekend working.

We were told the trust wide team tried to have EOLC facilitators based at the hospital twice or three times a week depending on commitments and need. There was always one SPCT CNS located on site from Monday to Friday, and if there was additional need then staff were allocated accordingly. The CNSs rotated between the two sites on a monthly basis.

In terms of how EOLC facilitators and SPCT CNSs were allocated between the two trust acute sites, we were told Queens Hospital was allocated more staff due to an element of not having as much work at King George’s, but also because of managing staffing numbers and allocating resources efficiently. There were a lot of meetings held at Queens such as business meetings and multidisciplinary meetings.

However, we were also told that things were changing, and the team were encountering higher patient complexity and more care of the elderly patients at King George’s, which meant staff resources would be reallocated with any increase on the rate of referrals, which were described as currently static. Introduction of the GSF had increased awareness in end of life care and recognition of when patients were dying. In terms of complexity, we were told this had changed for many factors that included cultural understanding and acceptance of dying and deterioration, including families wanting their dying relative to stay in hospital.

The SPCT caseload was, on the day of inspection, 12 patients at King George’s compared to 24 at Queen’s. Cases would vary day to day in number and complexity so each morning at the 9am handover resources were allocated as needed. The SPCT team manager was always based at King George’s on Thursdays where they also ran a communication workshop every two months for staff, which was equal across both sites.
In addition to the nursing staff, there was one occupational therapist, one social worker, one discharge coordinator who covered both sites, but all had one set day at King George’s. With complex cases this could be changed as need arose. We were given examples of this and the flexibility of the service. There were also two administrators who were all full time.

The discharge coordinator post had been considered a success and the team were looking at planning for further role development. We were told that future development of the discharge coordinator role to weekend working was next to be considered. However, the local authority did not currently work weekends so this was not currently a priority.

Health care assistants (HCAs) we spoke with told us that if they could change one thing it would be to have more staff so there would be more time to spend with patients.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The table below shows a summary of the nursing staffing metrics in end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th></th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>Target</td>
<td>9%</td>
</tr>
<tr>
<td>All staff</td>
<td>31.3</td>
</tr>
<tr>
<td>Medical staff</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Medical staffing rates within end of life services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The SPCT and end of life care medical team were made up of four consultants and one associate specialist, totalling 3.5 whole time equivalent working across both sites. A minimum of two days a week (Monday to Friday) were spent at King George’s compared to five days at Queens Hospital. There was one consultant based on site on Monday and Friday. However, this could also be flexible based on patient need. In addition to the two days, face to face consultant cover was provided Monday to Friday on request. We were told this reflected the clinical demand rather than being due to lack of resources. One SPCT consultant worked in the community, attending the MDT and rotated every other week with hospital work.

Medical staff told us that in terms of what they would like to improve, there was a need to increase the size of the palliative medical team by at least one whole time equivalent (WTE). Additional medical resources would better support innovation and research which in turn would lead to ongoing
improvement in care. Currently clinical care was given priority therefore innovation and research was slowed down, but not ignored.

Records

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

Records were a mix of paper and electronic. Nursing records were included in the paper medical record, bedside folder (risk assessments, ongoing care updates, individualised end of life care plans) and an electronic system for clinical observations. Individualised end of life care plans and Proactive EnhAnced CarE (PEACE) plans (designed to avoid inappropriate readmission to hospital of a dying patient) were paper based. The SPCT provided support if needed with discussions and plans. GSF paperwork and DNACPR forms were held in the medical notes.

Ward notes in use were held in cabinets so not viewable to the public. On Fern ward, notes were stored in a locked records trolley (key pad) located at the ward reception desk. This was checked on several occasions throughout the inspection and found secure at all times. There were no records that were not in use that were not secured in the trolley.

Admission to the mortuary was documented by nurses completing a form with patient details on the ward and porters completing a section of the same form on delivery to the mortuary, which included fridge number and signature. This was then entered on to the new electronic record system. The system was colour coded yellow and purple for completion by either mortuary or bereavement staff. This included certificates, next of kin, body condition, arrival time, GP details and place of death. The system went live a month prior to our inspection. The system had the capability to measure mortuary capacity across the trust and showed 69 occupied fridge spaces and 80 available. It also had the capacity to measure place of death which could be helpful with mortality reviews. Analysis of trends and causes of death were also possible but not in place yet. The system was currently embedding.

Five sets of records were reviewed on Fern ward, primarily for EOLC documentation. GSF screening and action forms were completed in all records. There was good evidence of patient and care involvement in discussions and decision making. The documented discussions with patients and/or families were clear and detailed. The agreed plan of care was detailed. In one record the agreed plan of care had not been enacted, the reason why (change in main carer health) was clearly documented and new plan agreed with son. One PEACE plan was available to review. It was fully completed, detailed and personal to the patient. One individualised end of life care plan was available to review. This had been fully completed and included individualised care plans that had been agreed with the patient’s son, such as the repositioning schedule. End of life medicines had been prescribed. Pain scores were recorded in the electronic system.

Five sets of records were reviewed in the bereavement office, including records from patients in ITU, Fern and Holly wards. Overall records were completed to a good standard. We saw good documentation of discussions and involvement in decision making with patients and families, consistent prescribing of end of life medicines and consistent recording of pain scores. Not all patients identified as dying were commenced on the individualised end of life care plan. However, this was more consistent on the GSF accredited ward, this also reflected the monthly audit and metrics data. Not all care plans were fully completed, this is also reflected the monthly audit findings.
## Medicines

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

We observed appropriate stocks of anticipatory medicines held on wards, used in anticipation for dying patients. Drugs were all secured safely, in locked cupboards in locked rooms. Controlled drugs were kept in locked controlled drugs cupboards with a book to record medicines.

The EOLC facilitator reviewed all drug charts following patient death and despite a low criterion to fail, such as one omission on the whole chart equalled a fail, the current fully completed charts was more than 90% trust wide. Drug charts we observed had been reviewed following a recognition of dying and medications rationalised with non-essential medications discontinued. This complied with national guidelines.

There were two advance nurse practitioner CNSs working in the SPCT. They were utilised for the provision of PRN medication particularly at the point of dying. The SPCT worked with medical staff on the wards to support the prescription of anticipatory medicines through telephone calls requesting advice. Guidelines for general medical staff were available on the intranet and were often printed off for doctors.

We were told there used to be an issue about anticipatory medicines due to lack of confidence in prescribing but the 24-hour on call palliative consultant cover had significantly improved this. The service received an average of a couple of calls a night across both acute sites.

## Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2018 to July 2019, the trust reported no never events for end of life care.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from August 2018 to July 2019.

(Source: Strategic Executive Information System (STEIS))

The trust’s electronic incident reporting system was used to break down information to deduce if an incident related to end of life care. This information was automatically shared with the SPCT lead who identified learning actions such as educational needs. We were given the example of a syringe driver incident at the beginning of the year which was investigated by a SPCT team member, audited and then audited three months later to measure improvement. The SPCT team leader and the head of quality and safety confirmed that there have been no incidents classified as either Never Events or Serious Incidents for end of life care in the year to date or last year.

All CNSs we spoke with were familiar with the reporting system and process and gave clear examples of how and when an incident report should be completed. We were also provided with clear examples of feedback and learning.
We spoke with six members of ward staff who all demonstrated good awareness of incident reporting. Health care assistants we spoke with had good awareness of incident reporting and how to access and use the electronic reporting system. We were told the trust was an open and honest organisation and staff were encouraged to report incidents. Any incidents from the ward and across the trust were shared at the daily huddle, there was also an open monthly meeting where staff were encouraged to attend and where learning was shared. They were aware of Duty of Candour and the importance of being open and honest.

We were told by senior SPCT staff that the team were aware of their role in relation to the Duty of Candour and that a culture of candour existed as the team were open and honest with patients and relatives. We were told the team would explain to patients and families and offer information around action plans resulting from incidents.

The trust’s patient safety summit occurred weekly and could be attended by anyone from the hospital. There was an SPCT presence at the summit every three months when a case was presented by them from an incident which was followed by discussion and reflection and any actions from the group taken forward to focus on learning.

End of life metrics that were reported to the board quarterly and to the monthly clinical governance meetings included complaints and incidents. We saw a report for September 2019 that stated three incident reports. Two involved syringe drivers and one relating to medication. All three had been reviewed and an action plan had been formed to provide additional training for ward areas involved.

All mortuary incidents were reported through the trust’s electronic incident reporting system. We were given an example of an incident that occurred a month ago and of the investigation that followed. This demonstrated a clear process of reporting and investigation.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The individualised end of life care plan (IEOLC plan) was developed by the trust in 2015 and replaced the Liverpool Care Pathway. The IEOLC plan had been reviewed and updated since this time and the current version in use was version 5. We were told that through audit and review, significant improvement had been made to the care plan, with reduced content, improved layout to indicate responsibilities and more visibility of key aspects.

The IEOLC plan was evidence based and conformed to recommended best practice, being built around the five priorities for care as recommended by the Leadership Alliance for ‘Care of Dying People’, 2014. The IEOLC plan allowed for the achievements of the five priorities for care. These included recognition of dying, sensitive communication, shared decision making, needs of families and a care plan that included food and drink, symptom control, psychological, social and spiritual care. In addition to meeting the guidelines of the 5 Priorities of Care, the IEOLCP also met the requirements of NICE NG31 and NICE QS144.

The end of life care facilitators reviewed all IEOLC plans. Their latest data showed that in July 2019, 60% of patients who died at the trust had an IEOLC plan. Ongoing support was provided by the facilitators to the wards to promote its use. The overall trend of its use was reported to be going up as a result of their work.
In addition to the number of IEOLC plans, the quality and completeness of data was also collated and sent to each ward. A recent initiative was that ward leads had to respond with an action plan indicating how improvements could be made. Education and training were provided by the EOLC facilitators to help wards to achieve improvements in outcomes of action plans.

We observed the individual end of life care plan (IEOLCP) in use. It had been appropriately completed by doctors and nurses. There was assessment of symptoms including pain, nutrition and hydration.

We were told that advance care planning (ACP) was also a primary focus of the EOLC facilitators. The trust used an established ACP tool ‘Thinking Ahead’, there was a patient information leaflet to support the tool. The EOLC facilitator we spoke with was knowledgeable about the ACP such as how it improved outcomes relating to preferred place of care and readmission avoidance. The use of the ACP was actively promoted by the facilitators through direct staff interaction with patients and through staff education, which might include teaching or supporting staff when they go to see a patient. All ACPs were uploaded on to the electronic systems used by the wards and ED, so were able to be viewed across the hospital and ED.

PEACE plans were an NHS England initiative designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP. The plans were available at the hospital and were used for patients living in nursing homes and residential homes. During the past 18 months this had been extended to incorporate people living in their own homes. They were predominantly written by medical staff and were used to record appropriate parameters of care for EOLC patients and could support readmission to hospital when this was the patient’s wish. They were uploaded on to ‘Coordinate My Care’ (CMC – a clinical service that holds patient care plans) and so were viewable to external care providers such as ambulance service, 111, GP, hospice and care homes that were signed up to the scheme.

Fern ward implemented use of the Gold Standards Framework (GSF) was in February 2019 this year and accreditation was achieved in July. The achievement was celebrated and acknowledged by the trust including a trust award ceremony in September. The ward told us they received good support from the EOLC facilitators during the implementation and accreditation period. Gentian, Holly and Erica wards were working towards accreditation. EOLC facilitators were training and preparing wards for staff working towards accreditation.

### Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Nutrition and hydration at King George’s was assessed and monitored through the individualised end of life care plan (IEOLCP). The IEOLCP was clearly focused on the ‘5 Priorities of Care’ which was a recommended National guideline. The IEOLCP was thorough in addressing and assessing nutrition and hydration, including being part of the initial medical assessment. It was also given priority in the nursing care plan (recognising the need for patients/families to be involved in decision making), and continuously through on-going daily assessments which were recorded within the comfort rounds. Also, within the IEOLCP the ‘Braden Assessment’ was used, which includes a component on nutrition. We observed the IEOLCP in use. It had been appropriately completed by doctors and nurses. There was assessment of symptoms including pain, nutrition and hydration. The end of life care facilitators reviewed every IEOLCP to monitor compliance.
Nutrition and hydration are covered within Mandatory Training for EOLC at King George’s, for level 3 training which is a full day teaching for ward based staff, the Speech and Language Therapists (SALT) supported the EOLC facilitators and Palliative CNS with a session on nutrition and hydration.

We were told there was a weekly complex nutritional MDT between the SPCT consultant, gastro consultant and SPCT CNS. The nutritional team also handled cases referred to them. The MDTs took place at Queen’s Hospital for King George’s patients. We were told that people would come across to the hospital to action any decisions.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.*

Pain scores were recorded in the electronic system using a scale of 1 – 10 and the Abbey pain scoring tool was used for patients who were not able to communicate their pain level. Pain was recorded in an electronic system for monitoring the vital signs of adults in hospital and in their individualised end of life care plan. Ward staff told us for assistance with pain management, they would usually access SPCT staff in the first instance and involve the pain team if needed.

We observed a 9am board meeting in relation to end of life care on Fern ward. There were discussions around the pain management of patients, including need to involve pain team.

Senior SPCT staff told us the SPCT worked with the hospital pain team in several ways. There was a lead for the acute pain team and both were aware of each other’s services as patients were sometimes seen by both. The pain team usually referred to the SPCT. Joint visits involving CNSs from each team occurred for handovers or where there were complex or difficult cases of pain in order to provide different perspectives. The SPCT had a meeting with the pain anaesthetist fortnightly and the SPCT would hand over to the pain team for specific reasons such as for surgery.

**Patient outcomes**

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

National Audit of Care at the End of Life April 2019 (outcomes from 2018/19). The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in One Chance To Get It Right and NICE Guideline (NG31) and Quality Standards (QS13 and QS144). King George’s Hospital survey outcomes are as follows:

Recognising the possibility of imminent death - 9.1 (national average) /9.5 (hospital average)
Communication with the dying person – 6.9/8.7
Communication with families and others – 6.6/6.0
Involvement in decision making – 8.4/8.4
Governance - 9.5/10
Workforce/specialist palliative care 7.6/10

Individual plan of care - 7.4/6.3 - While scoring higher on most pointers for individual plan of care, documented assessments of nutrition and hydration between recognition and time of death were lower. However, the hospital scored higher than average for the management of pain and symptom control, receiving fluid and nutrition. The hospital also scored highly when asked if staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life, and that staff at the hospital made a plan for the person’s care which took account of his/her individual requirements and wishes.

Needs of families and others – 6.1/3.1. While scoring above the national average on most points, the service scored less well on access to counselling and psychological services and designated ‘quiet spaces’ available for relatives or carers.

We were told that with the introduction of the Gold Standards Framework, together with an increase in the awareness of advance care planning and better identification of dying patients, it was envisaged that work to support dying patients would increase at King George’s. We were told that metrics were trust wide, so it may not be possible to notice the difference in patient outcomes between the two sites but that there were some issues arising through the IEOLC plan such as communication.

Competent staff

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

From April 2019 to June 2019, 92.6% of staff within end of life care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Scientists</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Appraisal rates for SPCT and EOLC staff, mortuary services staff, bereavement officers and pastoral care staff were given as 100% for the last two years.

All new staff received end of life care education on induction. The chaplaincy were also involved in nursing and healthcare assistant induction and corporate induction. EOLC facilitators were instrumental in delivering increased and improved end of life care education across the trust. End of life care was now part of the ‘essential training’ for all clinical staff. Following this success, we were told there was now a need to also establish training for non-clinical staff.
All staff received end of life care training as part of their essential training, which was mandatory for staff. There were three levels of training depending on their exposure to End of life care. Level 1 was for non-clinical staff with non-patient contact roles, which was via e learning and assessment. Level 2 was for clinical staff with infrequent patient contact, which was two-hour face to face training. Level 3 was for all clinical staff who provided hands on care such as ward nurses. This was a full day study delivered by a multi professional team including SPCT, chaplaincy who covered spiritual care, mortuary staff, speech and language therapy who covered nutrition and hydration and EOLC facilitators. Level three was currently provided on a rolling programme every two months.

The EOLC team did training for ward staff to enable better identification of patients who were deteriorating or dying. There was a focus on teaching of ward staff that included prognostic indicating framework from the Gold Standards Framework. Staff received training on GSF. End of life care facilitators supported training on the wards and provided ward based learning that included one to one training for new staff if needed.

There were three EOLC facilitators across the trust who worked on both of the trust’s acute sites. One of the facilitators was present at King George’s three days between Monday and Friday. We were told that this was not a resource issue but reflected need. If an EOLC facilitator was required on a day when they were not scheduled, they would travel across to support direct patient care. For instance, to support a staff member to have a sensitive conversation.

Breast and neurology cancer care were based at King George’s. The EOLC facilitators carried out bespoke training on wards. The service was responsive to individual training needs as they arose. We were given examples such as how to start conversations about death, individual end of life care plan, syringe driver use when lock boxes had been introduced.

We spoke with one health care assistant who told us that EOLC training provided had been good and it supported the expectations around care. We spoke with members of the ward and multidisciplinary teams on wards. On Holly ward we were told that training in end of life care and implementation of the GSF was good. On Fern ward we were told there was one day, face to face training on end of life care, ward-based training and shadowing opportunities. There was one day face to face training for EOLC champions. There were specific responsibilities for EOLC champions that included maintaining standards, ward-based training and updates and maintaining the GSF register. The EOLC champions programme had recently been relaunched, clarifying the role and expectations, making it a more effective role which had been redefined with support from the SPCT and EOLC facilitators. There was a relaunch in September 2019. Training days had taken place with clearer expectations which included the roles supporting audits, implementing end of life care standards and being a resource for their own teams.

Senior SPCT staff told us the successful transition from care plan to individualised end of life care plan happened due to what had been taught to staff. Ward MDT discussion involved SPCT and EOLC team staff giving advice and they were also asked for their input when visiting wards.

The ‘10 at ten’ started in oncology at Queens Hospital and was for a ten-minute training session to take place around the board. We were told the SPCT had used it on Holly ward and care of the elderly wards. On Holly ward, a ten-minute teaching session recently took place to raise awareness around end of life care issues such as advance care plan, fast track and pain control. There was also a lot of sessions with Fern ward prior to GSF accreditation.

Regarding end of life training for doctors, we were told that all foundation programme doctors received a session on palliative and end of life care as part of their routine training. Additional training was provided to relevant specialty teams as needs are identified based either on our end of
life care metrics or complaints. Specific communication skills training was available for all staff including doctors and bespoke sessions are arranged for whole departments on request. The SPCT were currently in the process of developing essential training for all doctors, encompassing both e-learning and face to face sessions to cover appropriate NICE guidance and relevant training curricula.

End of life care education was given to medical staff across the trust. This included a bespoke one to one work based advance communication training for consultants. All junior doctors including foundation and core medical doctors received a minimum of half a day training a year. On request, training to different directorates and departments was provided such as in clinical governance sessions. Informal training was given to doctors on the ward and e-learning modules were also available.

All the CNSs we spoke with had undertaken a course in advance communication skills. We were informed that all CNSs were expected to hold a certificate in advance communication or be working towards it if new in post. Two of the SPCT CNSs were accredited trainers for advanced communications and two of the palliative doctors ran communication sessions for senior medical staff. Communication workshops were run quarterly and were available to all.

Regarding the education and development of SPCT and EOLC team members, we were told there was opportunity for education, with needs identified through appraisal and interim appraisal. One CNS was undertaking a masters in end of life care, another was undertaking the advance nurse practitioner’s qualification. Other opportunities that arose were offered to the team by their line manager. For instance, there were offers of study days by a local hospice and the CNSs felt these were allocated fairly.

There was a weekly teaching session for one hour for the SPCT and EOLC team. All members of the both teams were included, including the social worker, occupational therapist and discharge coordinator. Team members contributed to the teaching rota, but it also included speakers from other areas of the hospital and from external speakers. We were given examples of recent speakers.

The lead chaplain contributed to the teaching of a post graduate course on chaplaincy at another hospital and took placements on within the trust.

The SPCT were involved in the training of staff for syringe driver use and had undertaken initiatives to improve access to syringe driver training that had included an instructional video and operational guidelines on the palliative care page of the trust intranet. Staff using syringe drivers were expected to have undertaken training and passed a competency process to use them but in practice it was not possible to identify how many trained nurses had obtained competency and there was no comprehensive list of who had received the training.

The EOLC champions programme had recently been relaunched, clarifying the role and expectations, making it a more effective role which had been redefined with support from the SPCT and EOLC facilitators. There was a relaunch in September 2019. Training days had taken place with clearer expectations which included the roles supporting audits, implementing end of life care standards and being a resource for their own teams.

Care after death training was considered important for best practice for all nurses and healthcare assistants. This was a two-part training module that included a mortuary visit for familiarity with mortuary processes and how the mortuary was managed and run. This also included how to talk to relatives. This was initiated following instances observed by mortuary staff relating to adequate preparation of bodies by ward staff and a need for better communication between the wards and the mortuary. Modules were devised by the mortuary lead and the training commenced in July 2018.
Training was taking place as at Queens Hospital for staff from King George’s. Currently, trust wide, 93% had completed e training and 800 of 1400 had completed their mortuary visit. We were told that ward staff visiting the mortuary had proved a positive way of allaying ward staff apprehensions about care after death and although there was more to do, having achieved over 50% of staff visiting the mortuary was considered positive progress towards a three-year target of meeting training compliance. It was not possible to break down how many staff from King George’s had been trained.

The mortuary manager offered weekly training for porters on a Wednesday. They explained the process from the ward to the undertaker step by step and covered different types of scenarios that included respectful behaviour around families, issues with the shrouding of the body and the capacity of fridges out of hours.

Porters told us the training focussed on the task being different to other portering tasks and emphasised dignity and respect of relatives and the deceased. 75% of porters had received the training. The aim was 100%, but due to natural staff turnover this was a challenge which had been made easier by the regularity of training sessions.

**Multidisciplinary working**

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

There were good relationships with different departments and multidisciplinary teams around the hospital that had been built up by both the EOLC team and SPCT. We encountered team members engaging with ward staff in positive ways that included care of patients and education. The team also attended numerous board rounds on wards. Ward managers told us they were well supported by the SPCT seven days a week and by the EOLC facilitators. The SPCT had a lot of input with care of the elderly patients with neurology, renal and heart failure multidisciplinary team meetings were held on site. The team were also asked to attend some governance meetings with consultants and leads on site. A lot of multidisciplinary meetings for King George patients occurred at the Queen’s Hospital site. For instance, nutritional and pain MDTs occurred at Queens for King George patients. We were told that clinicians would come over to action the outcome of any discussions.

Urology CNSs’ main focus was supporting patients with urology issues and supporting them through treatments. There was evidence of collaboration with the SPCT, EOLC facilitators and GPs to provide end of life support. The breast cancer CNS team consisted of six band 7 CNSs working across the trust and in collaboration with the SPCT.

The EOLC team met monthly with the community teams from each of the three boroughs within the trust’s catchment area. There was a Barking, Havering and Redbridge end of life steering group which brought together community teams for the three boroughs of the trust community, which was the first step towards integrated care for end of life care between the community and the trust. A joint EOLC strategy had been compiled together following the teams agreeing to work towards providing an integrated service. There was now one DNACPR across hospital and community.

We were told there was regular contact with GPs through telephone calls with SPCT members for specific reasons such as for discharge. There was a Macmillan GP liaison officer who coordinated communication within the trust. The SPCT were proud of their joint working with the local hospice, which included medical on call and education programmes.
Seven-day services

Key services were available seven days a week to support timely patient care.

At weekends there was one SPCT administrator and one SPCT CNS to cover both sites, with most of their time spent at Queens. Having one CNS covering both sites had been identified as a challenge that had been placed on the risk register. Because of this increasing demand, the service was currently three weeks in to a six-week pilot to allocate two CNSs to work at weekends. However, we were told that neither CNS had yet needed to come to King George’s. It was considered that the need for this will grow but at present the extra CNS could be better utilised at the Queen’s site.

Staff told us that pressure existed for Monday to Friday working so there was need for an additional person for the SPCT to maintain their current workload in the week. Funding had been created for a band 6 development post to work weekdays, which was intended as backfill for the gap left by the weekend working CNS. The aim was for the band 6 to develop in to a band 7 CNS and then the development post will be refilled.

Administrative support had begun working at weekends last year to reduce the need for CNSs to spend time on admin, thus freeing up their time with patients at weekends. We were told that moving towards integrated care had meant that the CCG had acknowledged this and will address it following the addition of consultants. Trust and hospice palliative consultants covered a 24-hour on call advice line. There were six in total and follow up was offered at weekends to relieve pressure on the CNSs. The service received on average a couple of calls a night.

At weekends, all viewings of deceased patients were carried out by the mortuary team who were on call for this purpose. We were told this worked out as each appropriate person being on call every four weeks. During out of hours and in emergencies, the on-call mortuary staff were accessed as necessary by the site manager.

Health promotion

Staff gave patients and their relatives practical support.

Relatives were encouraged to contribute to giving care to their loved ones by ward staff and the SPCT. Senior SPCT staff told us relatives were shown how to provide mouthcare and assist with feeding where this was appropriate to do so. We were told this was promoted among relatives because it had a therapeutic and calming effect on patients and helped their wellbeing.

Relatives told us there had been good communication with all staff and told us they had all the information they needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April to June 2019 at trust level for qualified nursing staff in end of life care is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Mental capacity act</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>and deprivation of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>liberty safeguards</td>
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</table>

In end of life care the target was met for the one MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April to June 2019 at trust level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April to June 2019</th>
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<td>Completion rate</td>
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<td>88.9%</td>
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In end of life care the target was not met for MCA/DOLS training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The combined SPCT of six nurses were able to demonstrate a good understanding of the mental capacity act. All CNSs and occupational therapists from a variety of teams supporting end of life patients we met, had a good understanding of the deprivation of liberty safeguards (DoLS), when they might be required, how to initiate the process and how to access trust policy. Regarding mental capacity all were aware of the Mental Capacity Act and how it should be initiated. We were told that all trust staff of band 6 and above received additional training specific to the Mental Capacity Act.

We spoke with six members of ward staff who all had appropriate knowledge of DoLS. We observed two DoLS assessments that had been appropriately completed. We spoke with six members of ward staff who all had appropriate knowledge of capacity and the Mental Capacity Act. We observed a 9am board meeting in relation to end of life care on Fern ward. There was a good level of discussion around consent and capacity issues and team discussion around challenging DNAR discussions and decisions including family involvement to achieve the best decision for the patient.

The EOLC facilitator carried out continuous review of all do not attempt cardio pulmonary resuscitation (DNACPR) forms for patients who had died. We found that DNACPR forms had been completed to a good standard and countersigned appropriately by the consultant within 24 hours. There was good documentation of patient and family discussion. Forms did not include trigger questions relating to capacity, but we observed good practice and discussion of capacity.

We reviewed 17 DNACPR forms that were in place at the time of our visit. We found that all 17 of the forms could be found immediately at the front of the notes. All 17 of the forms stated the name and designation of the person completing the form and had been signed by them. All the forms had been dated when signed and all 17 clearly identified the rationale for the decision. All 17 indicated that the patient, their relative or next of kin had been involved in the discussion and all had been signed by the consultant.
Is the service caring?

Compassionate care

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

We were not able to speak with patients and relatives. We did encounter patients at the end of life and some of their relatives. However, it was not possible to speak with them because some declined and some patients were not well enough to speak with us. We did observe care and review the results of the bereavement survey, completed by relatives 12 weeks after the death of their loved ones, which asked them about theirs and their relative’s experience of care. We also read several cards that had been sent to wards by relatives that related to end of life care.

We saw dozens of thank you cards on wards. The main messages were thanking staff for their kindness and friendliness. For instance, one card was from a relative who worked in a hospital and wrote they knew how difficult looking after their loved one had been but was grateful for how kind and efficient staff had been. We found the staff and atmosphere very friendly on the wards. Staff were very busy but also efficient.

We observed people being treated with compassion and dignity. Ward staff were very caring. There was a relaxed and friendly atmosphere despite of how busy they were. We were impressed by the spirit and care of the staff.

Health care assistants we spoke with told us they were proud of “the patients, helping them to recover and building a trusting relationship”. On Fern ward, staff told us they were proud of their teamwork with common goals. Staff sat with patients who were dying if they did not have family visiting so they did not die alone.

After death, relatives were provided with the ‘because we care’ leaflet. Staff were aware of the importance to give family time at the bedside with the deceased patient if needed. Staff reported the bereavement office staff to be very supportive.

Care after death had been promoted in the hospital since July 2018, when the mortuary lead began training sessions for nursing and healthcare assistant staff. This promoted a culture of the care and dignity of the deceased. Porters told us that since this training had been introduced, instances regarding ward staff’s appropriate shrouding of deceased patients had greatly improved. Porters training around mortuary processes and the transfer of deceased patients to the mortuary emphasised the care and dignity of the deceased patient and sensitivity towards relatives.

The bereavement office sent a condolence card to the family of the deceased. A bereavement survey was sent out 12 weeks after. Survey results formed part of the divisional monthly metrics and were shared with divisional leads to disseminate to the appropriate health care professionals and form part of the divisional action plan that is submitted to the end of life care operational group.

The survey asked the following questions: Did the healthcare team explain your relative/friend’s condition and/or treatment in a way that was easy to understand? How would you rate the way in which hospital staff treated any discomfort (for example pain or agitation) your relative/ friend experienced? How would you rate the emotional/psychological support you and your relative/friend received from hospital staff? (e.g. doctors, nurses, chaplains, physio’s, OT’s, porters, domestics etc.) How would you rate the dignity and respect you and your relative/friend received from hospital staff?
How would you rate the help and care your relative/friend received in the very last days of their illness? (washing, dressing, toileting and shaving)? How would you rate the place and way in which you were told that your relative/friend was dying? How would you rate the way in which the hospital worked together with your relative/friend's GP and other services outside the hospital? How would you rate the support you received from the bereavement office when you collected the medical cause of death certificate? Were your relative/friend's belongings handed to you in a white bag with a flower logo? Were you given a ‘Because We Care’ booklet? Were you given a card when you collected the medical certificate from the bereavement office with the divisional nurses' contact details?

Trust wide, the response rate for the bereavement survey for 2018 to 2019 was 26.2%. The bereavement survey results were positive, with all question responses rated in the 84-96% as either good or satisfactory. The survey results formed part of the divisional monthly metrics and were shared with divisional leads to disseminate to the appropriate staff. Action logs were attached to each question, demonstrating progress with each.

**Emotional support**

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

The chaplaincy were involved in supporting dying patients and their loved ones. 80% of their referrals were from the SPCT and EOLC teams. They also attended a lot of ward rounds where they picked up a proportion of their work by engaging with patients and relatives. They attended the patient experience committee and the equality and diversity committee.

The chaplaincy made the distinction between spiritual and pastoral work and the significance of providing both services to people based on need and choice. We were told that most of their work was providing emotional support to people who needed someone to talk to. The chaplaincy team visited most wards and had volunteers to carry out pastoral work. There was chaplain presence at the hospital every weekday. Chaplains did daily patient rounds and visited the staff based in the bereavement office every week. There were also volunteers carrying out pastoral visits seven days a week who also referred people to the chaplaincy. On Fern ward staff reported good access to chaplaincy and spiritual and pastoral services, which they found responsive. Out of hours, this was available via the switchboard.

The chaplaincy engaged in several other activities that promoted emotional support for patients, relatives and staff. They carried out end of life prayers and contract funerals for baby loss and for adults with no next of kin. This was a negotiation between the trust and the local authority. The chaplaincy also carried out training with the emergency department, the SPCT and EOLC facilitators on spiritual aspects on the care of the dying. In terms of developing the service, there was a plan to bring in a specific bereavement chaplain. The chaplaincy service won the patient experience national network award 2018.

An initiative started by the chaplaincy was ‘mourning coffee’, in partnership with Macmillan and the SPCT. There was one in each of the three boroughs the trust worked with and each occurred monthly in the community, for people who had been affected by bereavement in the trust's hospitals. This had proved to be a well-attended and successful support group for emotional support and linking people in to other community resources such as community health services to GPs and other counselling services. Themes such as power of attorney, coping with death, grandparent’s role and family had been covered in the mourning coffee groups.
The daisy logo was used throughout the hospital to indicate priority for the care of the dying. This was placed on the door of rooms so people were aware of dying patients. The EOLC team launched the daisy branding as it met a need that everyone accepted as being important. A flower was used due to most wards being named after flowers, which made it more appropriate way of communicating patient need in this area. The idea was taken on board with porter teams and now covers on concealment trolleys had the daisy symbol on them. Porters were aware of the daisy symbol and its meaning around the hospital. Porter staff were invited to talk to the mortuary manager for informal pastoral chats following any traumatic incidents.

Emotional support was part of the holistic assessment carried out by the SPCT. The social worker was also available to provide emotional support and the team also referred to the pastoral team. Carers' needs were identified during holistic assessments and the SPCT were able to signpost people onto services as required. The weekly MDT meeting for end of life care was attended by all SPCT and EOLC team members, the chaplain for discussion on complex patients, and the psychologist from the oncology service, who had input with oncology patients. They also provided mindfulness sessions for the team.

The National Audit of Care at the End of Life April 2019 (outcomes from 2018/19) showed that the service scored above the national average on most points. However, the service scored less well on access to counselling and psychological services. Counselling services for non-cancer patients was described by key staff as an unmet need trust wide. There was a counselling service at the hospital for cancer patients and a designated counselling room which afforded appropriate privacy.

'Be kind to yourself' hug course was a Macmillan nurses initiative in place at the hospital. There were eight facilitators for this who worked trust wide and was for cancer survivorship. The course ran for six weeks every Friday afternoon and was a wellbeing group. There was also a parallel course for patients' families. The scheme had been in place for 18 months and was for patients from all the London boroughs in the trust's trust catchment area.

The living with and beyond cancer initiative provided education on health and wellbeing. There was a 'help overcoming problems effectively' (HOPE) course. Benefits advice, a HOPE workshop for families and complimentary therapy team. All were available to patients receiving curative and non-curative (such as palliative) diagnosis.

The chaplaincy offered counselling as a staff support. Leaflets entitled 'need to talk' publicised drop in sessions to talk but also contained contact numbers if staff wanted to just talk. If there were traumatic events the chaplaincy were asked to do debriefings and told us they worked closely with the specialist palliative care team in this regard. They also saw their role as a staff resource that was outside of the clinical and ward environment where staff can talk.

**Understanding and involvement of patients and those close to them**

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

We observed positive relationships between staff and patients and relatives, where people were involved in all interactions regarding their care. It was also evidenced in care records we saw, which we found documented in the patient records on a regular basis. The Gold Standard Framework included thinking ahead and about what was important. Individualised end of life care plan, and the PEACE plan also sought to understand from patients and their families what was important to them.
The bereavement survey for 2018 to 2019 included asking did the healthcare team explain your relative/friends condition and/or treatment in a way that was easy to understand? A good or satisfactory outcome to this question varied each quarter. Quarter 1 was 81%, Q2; 95%, Q3; 80% and Q4; 90%. The trust stated in the survey that it recognised that having difficult discussions with patients and those closest to them could be difficult for health care professionals and that they provided training and support to ensure staff provided sensitive and easily understood explanations enable our patients and families to be fully involved in planning end of life care.

In relation to this outcome, there had been a few action points completed. They were: for the individualised end of life care plan to prompt discussion and care; the development of leaflets for patients and those closest to them; 1:1 communication training for consultants from the SPCT clinical lead; training sessions on level 2 and level 3 end of life care communication, with workshops open to all staff regardless of level or job title; bespoke training and support provided in the clinical areas; health care professionals to be encouraged to be present when the SPCT and EOLC facilitators have discussions with patients and those closest to them. One action was marked as still outstanding: Mapping of end of life care training for doctors and exploring making this part of their essential training, which was in progress.

Is the service responsive?

Service delivery to meet the needs of local people

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

The chaplaincy and pastoral service made 268 hospital visits between April to July 2019 but with fewer staff that the 269 visits were made with at Queens Hospital. We were told that the chaplaincy were trying to build things up at King George’s. Whatever was done at one site was replicated across the both. For instance, recent events such as a remembrance service and a day of Diwali were held simultaneously on both. The chaplaincy had a twitter feed and we were told everything they were doing was posted including all events. The week of our inspection was national interfaith week which was being publicised alongside the relaunch of the trust’s LGBT awareness initiative.

The chaplaincy told us that Marie Curie funding was recently applied for but was unsuccessful. However, they had come back to the chaplains and said they would like to provide some funding for specific end of life pastoral visitors, which was currently being worked on.

The bereavement office was open from 8am to 4pm every weekday. On average we were told there were 2 to 3 deaths a day at King George’s compared with 7 to 8 deaths a day at Queen’s. The bereavement office explained the process of issuing the medical certificate of death and working with the local authority registrar for the issuing of the certificate for a timely burial or cremation, who was based at the local town hall. A condolence card was sent out to the family of the deceased. A bereavement survey was sent out 12 weeks after.

The multifaith / prayer room was a small space that was primarily used as a Muslim prayer room by staff. There was no other multifaith / prayer / quite space available in the hospital which was recognised as an unmet need. The chaplains told us they were working on obtaining another space. However, there was no firm progress with this as yet. Side rooms on wards were used for infection prevention and the provision of end of life care. Wards were generally able to meet the demand for side room allocation for end of life care. For instance, we observed one ward’s 9am board meeting.
There was discussion around options to free up a side room for end of life care. The National Audit of Care at the End of Life April 2019 (outcomes from 2018/19) showed that the hospital scored above the national average on most points. However, the hospital scored less well on access to designated ‘quiet spaces’ available for relatives or carers.

It was also recognised that the hospital was short on ward space for sensitive conversations to take place on wards in private. There were day rooms, but it was difficult to find spaces for private conversations. For instance, on Holly ward the family room and the Willows room was used as a private quiet space for families. The willows room was used for meal times, patient activities and to meet with families when not being used for these purposes. The family room was in use for a discussion with a family member to complete a PEACE document at the time of our visit. Fern ward did not have a designated quiet/private area on the ward for discussions with families or for families to have time away from the bedside. Either the seminar room or ward managers office was used for this purpose. However, this could be problematic in terms of availability and both rooms had confidential patient information stored, so families could not be left alone.

The Cedar Centre provided a hub within the hospital that included office space for palliative and end of life services, urology and breast CNSs as well as patient services such as the ‘living beyond cancer’ service, counselling services for cancer patients and complimentary therapies.

There was a car permit scheme available to relatives of dying patients allowing them to park at much reduced rates. Open visiting was also permitted. A sleeper chair was available for relatives should the need arise for an additional chair bed, which could be accessed through the Cedar Centre or SPCT. Some wards had their own resources. For instance, on Fern ward, there were facilities for family and carers to stay overnight. The ward had two recliner chairs and a chair/sofa bed. We were told that ward visiting times were usually 10:30am to 7:30pm but there were no restrictions for patients at the end of life.

We observed a number of leaflets available for patients and relatives on aspects of end of life care including Proactive EnhAnced CarE (PEACE),(the plan was designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP), thinking ahead (advance care planning) and the end of life care plan, all available to patients and all available in alternative formats or languages through PALS.

The mortuary viewing area and relatives’ waiting area were basically decorated and lacked any warmth or human comfort. They were due to be upgraded. Queens Hospital mortuary viewing suite was currently being upgraded and we were told that King George’s was next. There was a staff photo board with names of all mortuary staff in the mortuary corridor.

All wards had a blue resource box with a daisy motif for end of life care information. All relevant end of life care documents were held in the blue box which had the daisy motif on. It included information for patients, relatives and staff. It included screening tools, assessments, patient and carer information and leaflets around end of life care. The daisy (gerbera) was the symbol for everything to do with end of life care within the trust. The logo appeared on leaflets, it was placed on patient doors or by the bed, on concealment trollies, on property bags. This was so it was discreetly and respectfully known by staff that to show extra sensitivity without making it over obvious. This was good for staff as it demonstrated patient focus and compassion.

After death, non-valuable property was kept on the ward for families to collect if they did not take it at the time of death. Property was kept on the ward for three months and then disposed of it not collected. Valuable items such as money and jewellery were taken to the cashier’s office or drop safe out of hours.
Porters were based next door to the mortuary. Porters followed a trust wide process for the transportation of deceased patients to the mortuary. Patients were already shrouded by nurses and we were told this was generally done to a high standard. We were also told that porters were confident in understanding the patient need to be shrouded and were confident in challenging this if it was incorrect. They were also knowledgeable about the need for the correct paperwork to accompany the patient. The deceased patient was transferred to the concealment trolley and ward staff spoke to patients’ relatives during the process. Porters were mindful of the need for dignity and of other patients during this process.

### Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

We encountered positive working relationships between the SPCT and specialist teams to meet individual patient need. The SPCT and EOLC teams engaged with ward staff in a number of ways that included the individual needs of patients and ward staff need for training and education in matters relating to end of life care. We spoke with members of the ward and multidisciplinary teams on Fern ward. We were told there was, good involvement of the EOLC facilitators and the SPCT and that both were very accessible and supportive in helping them meet patient needs. We spoke with eight members of ward staff who all stated they had no problems with accessing the SPCT nurses, doctors or EOLC facilitators. All staff stated that the SPCT were responsive to ward and individual patient needs. None of the staff we spoke with could recall a time when staff had not been available in a timely way.

The SPCT had built good relationships with different departments around the hospital. The teams attended numerous board rounds and multidisciplinary team meetings. They also linked in to the community teams and a joint EOLC strategy had been compiled to work towards providing an integrated service to increase the flow of information and integrate roles to meet patient need. There was regular contact with GPs through telephone calls with SPCT members for specific reasons such as for discharge. There was a Macmillan GP liaison officer who coordinated communication within the trust. The electronic discharge summary included a trigger for information on GSF, communication with the GP regarding thinking ahead conversations, fast track and end of life care.

The SPCT were part of the dementia strategy group. One SPCT staff member had completed a master’s degree on advance care planning for people with dementia. We were told that research so far suggested that advance care planning could work better, and the team were consulting patients and families on approaches that may work best for them. There was a mental health liaison service within the trust and who worked collaboratively with the SPCT. Their relationship was described as good and involved undertaking joint visits. We were also told the SPCT got quick advice by phone when required and the service was available seven days a week. There was a trust lead for learning disabilities who the SPCT worked with closely to accommodate any patient need. Both ward staff and SPCT staff made them aware of any patient need. This was described as a responsive service that offered good support including through joint visits and support to discuss complex issues. The lead also liaised with the community end of life care teams.

Regarding access to interpreters, we were told the interpreter system was always used for first assessment and was accessed through the intranet. If there was an urgent need such as if someone
was imminently dying, then digital translation could be used in an emergency. A member of the discharge team spoke four languages and was also often utilised.

A palliative outpatients’ service was provided at Queens Hospital which was also available to patients treated at King George’s Hospital. The service offered was flexible to meet patient need, with at least one appointment per clinic left open for urgent access or for someone attending the hospital for another appointment such as for investigation, so as to prevent the need to make another journey.

The chaplaincy were planning a lunch in January 2020 for all community faith leaders. This was to help build a wider community of faith so that ways to work together can be planned for the benefit of meeting the individual spiritual needs of patients. In addition to this, it was aimed at understanding the subtle differences of how to meet those individual needs and preferences of different communities. Another aim was to match by language and local faith community. The lunch was intended to strengthen these links. Some faith groups had been highlighted as harder to reach groups. This was to identify from individual faith leaders if they can meet individual patient need better.

Health care assistants we spoke with told us the dementia team were available to support care on the wards. On Fern ward we were told the dementia care team were sometimes involved with supporting families with discussions and end of life care decisions. On Holly ward, a Reminiscence Interactive Therapy Activities (RITA) screen was available to support patients. This was a digital therapy system which allowed patients to use apps, games and other leisure activities as part of their hospital recovery and was primarily used for elderly patients with cognitive impairments, such as dementia.

Mortuary hours were 8am to 11am. Opening hours were due to managing demand with available staffing across the trust. The mortuary was open in the mornings to meet service demand, which worked better for same day burial and cremation. Typically, a member of staff was on site Monday to Friday full time but needed the time outside of opening times to manage administration and records management tasks. This meant that someone was available outside of opening times if required. All viewings of deceased patients in the mortuary were carried out by the mortuary team who were on call at weekends for this purpose. We were told this worked out as being on call every four weeks.

***Access and flow***

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The SPCT led on complex and fast track discharges which had reduced the length of time to get patients home. The discharge co-ordinator was part of the SPCT, facilitating fast track discharges and hospice bed requests. Their role was to see and assess patients for suitability and liaise with ward teams and the SPCT nurses.

Rapid discharge was audited for quality improvement. In July, August and September 2019 there were 159 referrals for fast track discharge with an average length of stay from decision to discharge of four days. Referrals were usually seen on the same day and always for urgent referrals. Their role included speaking to the patient and family to discuss their preferred place of care and understand the challenges to this, especially when patient deterioration was rapid. They also liaised with care homes, community teams and the local CCG. A good relationship was reported with the CCG, who usually made a same day decision on funding.
Delays to discharge were monitored. We were told the most common challenges were the availability of suitable nursing home beds, the availability of hospice beds and authorisation and access to hospital beds and mattresses for patients going home. Discharge was also supported by the ward teams and the social worker in the SPCT. Patients for discharge were discussed at the SPCT’s daily handover and MDT meetings.

The discharge facilitator from the end of life care team organised equipment for end of life care patients returning home along with the therapist. We were told that hospital beds were ordered by the district nursing teams but all other equipment relied on varying processes depending on which London borough patients were returning to. This challenge was met by the discharge coordinator and therapists having a good knowledge of each borough’s processes, good channels of communication and referrals being made as early as possible. However, some district nursing teams were reported as not ordering a bed until discharge had been confirmed. The SPCT had a stock of equipment to assist with discharges such as slide sheets and commodes which were used in emergencies to assist in achieving rapid discharge. Any issues that related to access to equipment for the home, were related to community partners and were difficult to mitigate beyond what was already in place.

The service was transitioning to Coordinate My Care (CMC) from the PEACE Plan, which was used for people going home as well as those going to a nursing home. 82% of people with the document died in their desired place of care. Information was currently duplicated on CMC, but the service did not want to lose the paper-based system yet in case of gaps while people transitioned over. Regarding preferred place of care, ward staff told us that the SPCT were very supportive in assisting achieving this which they managed most times. We were told that sometimes, if the patient’s condition deteriorated rapidly, this was not possible. Sometimes carer’s circumstances changed and they were no longer able to achieve this. For example, plans to fast track one patient discharge recently, had to be changed due to main carer injury. Also, some families wanted their relative to remain on the ward although it could be challenging on an acute ward. For patients registered on CMC outcomes were uploaded on to this database for external partners to access when required. GSF information was also shared with community partners including GPs, out of hours services, ambulances and hospices via confidential nhs.net email accounts. Paper copies were sent to care homes that did not have nhs.net accounts.

We were told that over the last two years there had been a big positive change in end of life care in the trust and the engagement with hospices, care homes and district nurses had also improved. Three members of the SPCT had become ‘trusted assessors’ for local nursing homes. This was an initiative that had been put in place to resolve delays to discharges to nursing homes due to delays in the homes carrying out assessments for admission. These relationships had been built up by visiting the homes and liaising with key people regarding what assessments were required and who could be trusted to carry them out. There was a now a standardised two-page admission assessment for admission that had the agreement of the homes, who had authorised SPCT ‘trusted assessors’ to complete on their behalf. This had reduced delays in discharges where wards used to wait for the homes to come assess patients as suitable. Provided data shows a reduction in discharge time from 7 / 8 days to 48 hours. This concept had been presented nationally and was now modelled for the continuing healthcare initiative.

There were monthly meetings between the SPCT lead and district nursing leads from each borough that discussed the transfer of care from hospital to community services. There was a referral system in place and cross boundary medication charts were now used in the community. The service was also looking to create an electronic district nursing form for authorisation for syringe driver use. A pilot had been completed and the process was due to begin a the week after our visit.
On Fern ward we were told that regarding access to hospice care, this could be challenging due to limited beds, but if a patient required a high level of specialist input and a syringe driver, then admission to a hospice bed could be expedited. Fern ward told us they received good support from EOLC facilitators and the SPCT for fast track and complex end of life care discharges.

The Pro active EnhAnced CarE (PEACE) plan was designed to avoid inappropriate readmission to hospital of a dying patient through better understanding the triggers and liaising with the GP. We were told that 10% of patients with PEACE plans in place returned to the hospital. All cases were reviewed by the EOLC facilitators, to identify any trends and reasons behind return to hospital for learning. Ward staff told us that regarding patients with a PEACE plan in place who were readmitted, that this was usually due to carer anxiety and acceptance of the patient’s condition. Any patients readmitted had a review of the plan and further discussion with family and carers. However, local care homes were good at following the agreed plan.

The electronic discharge summary sent to GPs and had a section for end of life care initiatives that included GSF. When the GSF was selected there was a drop-down box which could be used to identify the GSF stage, which gave the GP an indication of prognosis and indicating patients were either in their last days/ weeks, months or a year or less of life. The end of life section also allowed the transfer of information including DNACPR status, an advance care planning tool called ‘thinking ahead’, an advance decision tool to refuse treatment and the PEACE document.

SPCT referrals were accepted from any clinical area or disease site. Recent data showed a 50/50 split between malignant and non-malignant referrals. The SPCT were able to respond to requests for advice and support quickly. 90% were seen within 24 hours and 100% within 48 hours. There was an average of ten referrals a day, with an average of six known in time for the daily morning meeting when they were allocated. Later referrals could result in reallocation due to prioritisation. Emergency department referrals were prioritised.

In 2018/19 a total of 2082 patients were referred to the SPCT; 918 non-malignant disease, 995 malignant disease, 6091 face to face visits, 2440 episodes of telephone advice and 75 patients seen in outpatients.

A total of 2214 patients died at the trust (across both sites) in 2018/19. 1723 patients were known to the SPCT died during 2018/19. Therefore 78% of deaths at BHRUT (across both sites) were seen by the SPCT.

237 patients were discharged to their own home with a peace plan. 173 patients (73%) died outside of hospital. 34 patients (14%) died in hospital. 30 patients (13%) remained in the community.

The individualised end of life care plan audit showed that between April and August 2019 that out of 134 eligible deaths, the care plan had been used 60% of the time. Results could be broken down by ward and area for providing support on completion.

Every allocation of work was recorded by the porter management with the names of the porters, in case of any queries. Porters had a 30-minute response KPI for deceased patients. This was escalated to the porter manager if unallocated at 25 minutes. Porters brought the deceased patient’s notes to the bereavement office after transferring the patient to the mortuary. If this was overnight they would do the same. Once the notes were received, the patient details were entered on to the system and the doctor was contacted for issuing the certificate of death, after which the family were notified that the certificate had been issued. We were told this process was always tried to be completed in one day. The local demographic meant there was a greater number of Muslim and Jewish deaths at King George’s than at Queen’s Hospital, and success in issuing timely medical certificates of death was measured and reported on in their management report. We were told this was achieved most of the time.
Learning from complaints and concerns

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

From April 2018 to March 2019, the trust received one complaint in relation to end of life care at the trust (0.1% of total complaints received by the trust). The trust took 37.0 days to investigate and close this complaint. This was not in line with their complaints policy, which states complaints should be completed with 25 working days. The subject of this complaint was around the care to a patient.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints and compliments relating to end of life care were identified or learned from through discussion across all governance groups. End of life care issues were also identified by analysis of complaints. The SPCT’s clinical lead was cited on complaints relating medical staff and end of life care, which were then fed into the EOLC meeting. We were told this tended to be around communication and consultants were invited on to advanced communication courses to address any learning. Sometimes the SPCT took part in round table meetings with families to identify what happened.

End of life metrics that were reported to the board quarterly and to the monthly clinical governance meetings included complaints and incidents. We saw the report for September 2019 that stated three incident reports and no complaints.
Is the service well-led?

Leadership

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

The chief nurse was the executive lead for end of life care. We were told this had enabled the SPCT lead to have access to more key people and progress end of life care services. The chief nurse was also the chair of the end of life steering group and there were now strategic and operational end of life steering groups, both with divisional representation and patient partners. Medical staff told us that the chief nurse and medical director were very supportive of end of life care and the SPCT had a good working relationship with the board. They had no concerns relating to the board’s commitment to end of life care.

There was a SPCT lead nurse and lead clinician and a separate end of life clinical lead based in the hospital and community on a rotational basis. The trust lead clinician job plan for their role was described as formalised and fixed. It was signed off at the last committee for end of life care. The SPCT lead nurse came to King George’s every Thursday and did a walk around to see what the live issues were and to be visible to wards and service leads. They also saw patients in order to be known among patient services and understand where the needs were, especially with wards commencing GSF.

There was a lead chaplain who coordinated and led chaplain services for the trust and worked closely with the bereavement office. They also sat on the UK Board of Healthcare Chaplains (UKBHC). This became accredited by the professional standards authority two years ago. The chaplain also chaired the Essex and East London Network of Chaplains. Both helped to link the chaplaincy in to the bigger picture for chaplaincy services locally and nationally. There were also training events for pastoral visitors every year through this network.

The mortuary lead had been in post for two years. They had raised the profile of the work of the mortuary services and the care and dignity of deceased patients. This included membership of group meetings and organising training for nursing staff and for porters.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The end of life care strategy for 2016 to 2021 identified achieving six priorities of care which were aligned to Care of the Dying in the Last Days of Life (NICE 2015), and Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020 (the National Palliative and EOLC Partnership). The strategy was updated to reflect updated guidance and presented to the board in May 2019.

It identified personalised care planning, shared records, comprehensive and robust data, involving, supporting and caring for those important to the dying person, education and training, 24/7 access, working with local patient experience groups and individuals with personal experience and leadership as key components to meet the six ambitions of care which were: 1. Each person is seen
as an individual, 2. Each person gets fair access to care, 3. Maximising comfort and wellbeing, 4. Care is coordinated, 5. All staff are prepared to care, 6. Each community is prepared to help.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Morale was evidently very high throughout the SPCT, EOLC team and the enhanced supportive care team. This was also the case for the chaplaincy service and bereavement service. These were all seen as rewarding roles for the staff involved, which combined delivering high quality and effective services with the excitement of new projects.

The chaplaincy told us they felt included and integral to the work of the trust. They were managed by the chief nurse and felt well supported and valued. Medical staff told us they were most proud of the standard of care given to patients, the whole team including chaplaincy, and the high esteem they were held in throughout the trust. They were also proud of the collaborative and joint working with the hospice and that clinical supervision was now mandatory and trust funded.

HCAs we spoke with told us the divisional and site leadership teams were visible and the executive team rarely came to their wards but did hold open meetings on site. We were told that sometimes it felt that the senior managers were a bit out of touch with what was happening at ward level, but the matron was very supportive and accessible. We spoke with members of the ward and multidisciplinary teams on Fern ward. We were told the executive team came to King George’s and held open meetings. We were told it felt like it was one trust. Ward staff told us there was a conscious effort by the senior team to ensure there was parity between the two acute sites of the trust and that it felt like one trust not two separate sites.

The SPCT demonstrated flexibility in utilising their multidisciplinary resources across the trust’s two acute sites which was done according to risk assessed patient need. However, resources were weighted against the King George’s site, where it was felt there was less of a need for end of life care services. SPCT staff were aware of rising level of patient need at King George’s and how an increased awareness in end of life care and recognition of when patients were dying would grow at the same time. However, as it stood, end of life care at King George’s had a lower profile than its trust counterpart.

Governance

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

The SPCT were integral members of the end of life committee, which helped identify and initiate end of life improvements in the trust. The chief nurse was the chair of the end of life steering group, which had boosted the profile of end of life care within the trust which was now joined up with community services. There were now strategic and operational end of life steering groups. Both had divisional representation and patient partners. Regarding the EOLC steering group/committee, medical staff told us there was appropriate representation from clinicians from King George’s on the steering group, partly because key staff worked across both sites.
The EOLC team met monthly with the community teams from each of the three boroughs within the trust’s catchment area. There was a Barking Havering and Redbridge end of life steering group which brought together the community teams for the three boroughs, which was the first step towards integrated care for end of life care between the community and the trust. A joint EOLC strategy had been compiled together following the teams agreeing to work towards providing an integrated service providing: increased flow of information and working, and a future plan to integrate roles. There was now one DNACPR form across the trust and community.

Mortuary services came under the trust division of cancer and clinical support. This arrangement had been in place for the last six months and previously came under the management of pathology. It was reported that this arrangement enabled greater assurance and accountability which was supported by the new divisional lead. Monthly mortuary reports went to the divisional meetings for cancer and clinical support. We were told that the SPCT and EOLC team had a good relationship with the mortuary manager, who linked into the EOLC committee and contributed ideas to the action plan. They were responsible for setting up training for nurses and HCA staff that included a mortuary visit including the viewing room, mortuary processes and changing practice to improve the way people were laid out.

The chaplaincy came under the trust division of patient experience. This arrangement had been in place since 2015.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The ‘Improving end of life action plan 2019-2020’, was based on the priorities of NICE Supportive/Palliative Care guidance and National End of Life Care Strategy to ensure that the trust had a clear direction. Ongoing progress was highlighted against each agreed action. This was aligned to the end of life care strategy. It was reviewed at the specialist medicine directorate clinical governance meeting (monthly) and at the end of life care committee (quarterly). It was reported up to the quality and safety committee and the trust board. Monthly metrics were produced at a trust wide level, divisional level and ward level. All reports went to the end of life committee. Action plans had been introduced five months ago and sat with divisional nurses and discussed at monthly meetings. It was felt there was good ownership and engagement across different divisions. There was also a process of escalation to the chief nurse, the executive lead for end of life care, if needed.

There were monthly audits of all deaths completed by EOLC facilitators to identify patients for the individualised end of life care plan and areas of the care plan that had not been completed. Results were displayed on notice boards and discussed at team and board meetings. On Fern ward we were told that a monthly end of life audit was carried out by one of the EOLC facilitators. The ward received a summary of the metrics but not the detail behind them. For instance, what aspects of the individualised EOLC plan were incomplete. This information went to the matron in the first instance and for completion of an action plan to address areas of noncompliance.

In addition to this, the end of life care committee reported to the trust board every quarter with an updated action plan and on improvements that have been made. Each month EOLC metrics were produced to monitor progress of the implementation of the Individualised end of life care plan, all tools used for advance care planning including the Gold Standard Framework and feedback from the bereavement survey which were fed back to the divisions for action. A new task and finish EOLC
group had been started to look at divisional metrics and develop action plans to feed into the end of life care committee quarterly meetings.

End of life care committee minutes showed attendance from key staff such as chaplaincy, palliative consultants and SPCT team members. It also demonstrated attendance from divisional matrons, service leads from the trust and senior representation from key partners such as the community hospice. Action logs, end of life metrics, audits, progress with GSF were among regular agenda items. The end of life task and finish group met monthly with representation from trust divisions to report on progress and challenges with priorities for end of life care and end of life metrics.

**Information management**

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust predominantly used paper-based records. Both paper and electronic systems were updated by the SPCT to ensure the information was readily available. There was an alert on the ward electronic patient information system and the electronic record system in use in ED to indicate if patients were on GSF or at the end of life. The alerts were added by the EOLC facilitators to both systems. The alert contained detail, where appropriate, of DNACPR status, the presence of advance care plans and preferred place of care and or death. The EOLC facilitators worked with ED to support the most appropriate care pathway for end of life patients.

The trust had recently signed up to Coordinate My Care (CMC), an electronic palliative care coordination system. This was currently in pilot phase on three wards. Expectation was that once CMC had been fully rolled out it would replace the PEACE plan. CMC was used in the trust and all teams in the community with end of life care responsibilities such as ambulances, GPs and care homes. GPs were now being incentivised to increase its use. This was now being filled out across the trust and community so that all end of life services could talk together. This included the use of one DNACPR form and communicating preferred place of care.

A new electronic information system had been introduced to record deceased patient details and track administrative tasks such as medical certificate of death, cremation papers, family contact, coroner’s referral, condolence card and if the deceased’ patient’s body could be released to family/undertaker.

**Engagement**

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

Patient experience meetings occurred on a monthly basis. They were attended by chaplains, matrons, the SPCT and ex patients who were now involved in the hospital and known as patient partners, who liaised and visited wards with patients and relatives. The SPCT presented and shared ideas and materials with the group. The EOLC committee also had two patient relatives as members. Through bereavement surveys, patients were involved in initiatives through patient stories including teaching and operational meetings. For instance, this was used for Dennis’s Den after receiving permission from patients and relatives to share their story.
Age UK volunteers had advanced care plan discussions and help patients complete ‘thinking ahead’ documents both in the hospital and at home. This was shortlisted at the Patient Experience Network National Awards (PENNA) 2018 as care navigators and recognised as a potential national initiative. The pilot started in a GP practice using Age UK as care navigators to put information on to coordinate my care. There were now two new volunteers who had been recruited to move this further forward.

There were quarterly meetings with the heart failure team and local hospice. This was introduced as a difficult to reach group. The hospital referred in to pick up patients unknown to the service.

Renal clinic meetings took place twice a month to discuss advance care plans. We were told this had proved very popular. A generic advance care plan clinic was being launched across the trust and in community bases for patients to be referred into.

An all borough (Barking, Havering and Redbridge) conference on end of life care took place in March 2019 at King George’s Hospital. This was a cross network conference organised by the trust to take a systems wide approach to end of life services, covering aspects of end of life care including community providers, nursing homes, local authorities, hospices and MacMillan. A&E attendance was covered, and a patient spoke about their experience of services. District nurses, GPs and consultants shared quality improvements around advance care planning and someone from the GSF also spoke.

**Learning, continuous improvement and innovation**

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

There were numerous initiatives, methods of learning and innovation in the palliative and end of life care services at every level of care within the trust. Some had been recognised nationally and some had been nominated for awards from national and leading organisations. These have been referred to throughout the report. For instance, a red bag scheme had been adopted by the trust. This was a bag containing information and the property of patients who were admitted from nursing homes, which was then sent back to the home if the patient died in hospital.

A recent patient focussed innovation included multi professional collaboration to provide an advance care planning (ACP) clinic for renal patients. This was nurse led and shared between renal CNSs, SPCT CNSs and the EOLC facilitators. Clinic slots were for one and a half to two hours so as to provide enough time for patients. Relatives were also encouraged to attend.
Facts and data about this service

The trust has 42 inpatient paediatric beds across two sites:

Queens Hospital: 55 beds located within two wards:
- Tropical lagoon ward – 30 beds
- Neonatal Intensive Care Unit (NICU) – 32 beds

King George Hospital: 18 beds are located in one ward
- Clover ward

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust had 6,080 spells from March 2018 to February 2019.

Emergency spells accounted for 78% (4767 spells), 21% (1278 spells) were day case spells, and the remaining 1% (35 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from March 2018 to February 2019, Barking, Havering and Redbridge University Hospitals NHS Trust.

Total number of children’s spells by site, Barking, Havering and Redbridge University Hospitals NHS Trust:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen's Hospital</td>
<td>4,550</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>1,530</td>
</tr>
<tr>
<td>This trust</td>
<td>6,080</td>
</tr>
<tr>
<td>England total</td>
<td>1,146,418</td>
</tr>
</tbody>
</table>
The trust provided the following information about their children's services department:

The trust provides general acute medical, surgical and some specialty child health services to a large number of children and young people (CYP) in the boroughs of Barking, Havering and Redbridge.

The trust had almost 52,000 attendances by children across the two children’s emergency departments (excluding urgent care/treatment centres) meaning that they make up circa a third of all attendances.

The department spans two sites, with two inpatient wards, two outpatients' departments, and a day unit. It has a level one paediatric oncology shared care unit (POSCU), level 1 children’s critical care unit, a team of clinical nurse specialists to support the care of children with diabetes, epilepsy, asthma and haemoglobinopathy and community nursing teams for the neonatal and children’s services.

The department has a level two NICU. During 2018/19 there were 650 admissions to the Neonatal Unit totalling circa 9,250 bed days.

The Medical Director is the named executive lead for CYP and she chairs the children and young people's group which ensures a trust wide approach is taken to addressing the needs of this age group.

The services are led by the lead consultant for child health, divisional director of nursing and specialty manager together with their teams.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)
Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, the rate of mandatory training compliance for medical staff did not meet trust targets. Data provided to us following inspection demonstrated that mandatory training compliance for foundation year junior doctors within the division stood at 65%, with GP trainees also only achieving 74% compliance.

All staff were required to complete relevant mandatory training modules as part of their induction and to complete refresher training, as required, in line with the trust’s training policy. Training was delivered through a combination of online assessment and practical training days.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff completed online training modules on the trust’s e-learning system. Staff told us they were given time within working hours to complete this training.

At the time of last inspection, we found that the paediatric intermediate life support (PILS) training for the theatre staff was not always complete. At the time of this inspection, we found that all theatre staff caring for children had completed their PILS training.

The trust did not report medical staff at this site as they reported medical staff working across both sites under a trust wide category rather than specifically here.

A breakdown of compliance for mandatory training courses from April 2019 to June 2019 for qualified nursing staff in the children’s services at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Conflict Resolution Initial Training</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Sepsis (Paediatric) eLearning</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non-Touch Technique (ANNT)</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Level 3 - Paediatric Immediate Life Support</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

At King George Hospital children’s services, the 90-95% target was met for eight of the 10 mandatory training modules for which qualified nursing staff were eligible.

Following inspection, we were provided with division wide data. Within the division, information governance training compliance stood at 97.4%, and paediatric immediate life support training compliance was 92.5%. Although the latter still fell short of the target, where staff had not received necessary life support training, the trust told us they had given these staff paediatric basic life support (BLS) training and booked staff in to attend this training.
A breakdown of compliance for mandatory training courses from April 2019 to June 2019 for medical staff in the children’s services that work across the two sites (trust wide) is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>41</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>39</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>38</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non-Touch Technique (ANTT)</td>
<td>37</td>
</tr>
<tr>
<td>Sepsis (Paediatric) eLearning</td>
<td>33</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>35</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>34</td>
</tr>
<tr>
<td>Information Governance</td>
<td>29</td>
</tr>
<tr>
<td>Conflict Resolution Initial Training</td>
<td>28</td>
</tr>
<tr>
<td>Sepsis (Neonatal) eLearning</td>
<td>2</td>
</tr>
</tbody>
</table>

Across the trust wide children’s services, the 90-95% target was met for three of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Data provided by the trust following inspection demonstrated that the mandatory training compliance of medical staff was still variable within the division. The data provided was not directly comparable to the above but showed an overall compliance rate of 78% with mandatory training for all grades of medical staff within the division. This stood at 79% for consultants, 81% for registrars, 65% for foundation year junior doctors and 74% for GP trainees.

Although not shown in the table above, medical staff compliance rates with either Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training stood at 100% for consultants and GP trainees, 89% for registrars, but only 29% for foundation year junior doctors.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The trust set a target of 90% for completion of safeguarding training.

The trust did not report medical staff at this site they reported medical staff working across both sites under a trust wide category rather than specifically here.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 for qualified nursing staff in the children’s services at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>11</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>10</td>
</tr>
</tbody>
</table>
At King George Hospital children’s services, the 90% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 for medical staff in the children’s services at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>36</td>
<td>39</td>
<td>92.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Across the trust wide children’s services the 90% target was met for two of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Within theatres, 98.2% of staff had completed safeguarding children level two training. The one staff member who was non-compliant had been booked to attend this training.

There were clear safeguarding processes and procedures in place for safeguarding children. The hospital’s safeguarding policies were within their review date and included information on female genital mutilation (FGM) and child sexual exploitation (CSE). There was also a clear policy relating to termination of pregnancy for children under the age of 13. Staff were able to describe the correct pathways as per the trust’s safeguarding policy to take in the event a safeguarding concern was identified. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a named safeguarding consultant and nurse within the ward. Paediatric safeguarding liaison nurses worked across sites. We saw information on how to recognise and respond to safeguarding concerns was visibly displayed within the department. Staff were able to describe recent safeguarding concerns and lessons learned as a result of these.

There were weekly multidisciplinary psychosocial meetings to discuss any concerns relating to safeguarding. Any safeguarding concerns or learning was shared in safety briefings, handovers and in the regular safeguarding supervisions that staff attended at least once every six months.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept most equipment and the premises visibly clean. However, the cleaning of toys in the playroom was not always completed and recorded. In addition, the monthly cleaning audit results were not provided to us, with only four months of compliance scores provided between November 2018 and August 2019. Other infection control audits did not seem to be consistently carried out.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.92 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016)
In the 2018 Patient-Led Assessments of the Care Environment (PLACE) survey, the hospital as a whole scored 99.4% for cleanliness against a national average of 98.5%.

The service had effective infection prevention and control (IPC) procedures in place. Safety systems, processes and practices were implemented and communicated to staff. The ward and outpatient area had an infection control link nurse. Link nurses acted as a link between the ward and the infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice.

There were comprehensive systems in place to prevent and protect people from a healthcare-associated infection. Between January 2019 and May 2019, the division reported no cases of MSSA methicillin susceptible staphylococcus aureus (MSSA). This is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning. There were also no reported cases of Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics). In the same period, the trust had two reported cases of methicillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection.

The service reported that there were no surgical site infections for children at the hospital in the year prior to inspection.

The department was visibly clean and had suitable furnishings which were clean and well-maintained. Personal protective equipment (PPE) such as gloves and aprons, was available throughout the department and we observed staff using it appropriately.

Staff had access to appropriate handwashing facilities. Staff, patients and visitors were reminded to use sanitising hand gel at the entrance to the department and when entering clinical areas. Monthly hand hygiene audits were carried out within the division. Between November 2018 and October 2019, Clover ward was found to be compliant with all standards audited.

Staff cleaned equipment after patient contact and used green ‘I am clean’ labels to indicate that it had been cleaned and was ready for use. There were appropriate processes in place to decontaminate reusable instruments and equipment. The monthly decontamination audit for the ward stood at 100% between November 2018 and August 2019.

At the time of the last inspection, we found issues with cleaning records and checklists not being completed. At the time of this inspection, we found these issues had been resolved for the most part. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Cleaning staff followed appropriate IPC procedures, including using specially designated colour coded equipment to clean different areas. Staff followed a daily cleaning rota and maintained a record of which areas had been cleaned. However, the monthly cleaning audit results were not provided to us, with only four months of compliance scores provided between November 2018 and August 2019. Other audits, such as those into aseptic process and isolation precaution, did not seem to be consistently carried out. In addition, the cleaning of toys in the playroom was not always completed and recorded as this was the responsibility of the play specialist, who did not work full-time until a rotation took place a few weeks before our inspection. The play specialist told us all toys that had been played with by a child with a potential infection were cleaned separately before being added back to the playroom. They were placed into a box for this purpose, which was regularly emptied of toys which were cleaned thoroughly before being returned.
Environment and equipment

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

In the 2018 Patient-Led Assessments of the Care Environment (PLACE) survey, the hospital as a whole scored 93.4% for the condition, appearance and maintenance domain against a national average of 94.3%.

The design of the environment was appropriate for the services being provided. The service had suitable facilities to meet the needs of children and their families. Care of children at the hospital took place in the inpatient ward, which was usually staffed for 12 children and young people but could take on more if necessary (with capacity for up to 18 children). There was a small children’s outpatient department attached to the ward, with two clinic rooms. All areas were safe for children and access was restricted to ensure no children could leave the department unattended.

The department had enough suitable equipment to help them to safely care for children and young people. The trust had a service level agreement with an external company for maintenance and electrical safety testing. We saw that equipment displayed a sticker with its most recent testing date and that all the items were checked were within date for testing.

Disposable equipment was stored appropriately, and all items we inspected were within their expiry date.

At the time of the last inspection, we found issues with the availability and checks of specialist resuscitation equipment for all age ranges in the scanning and theatre areas. At the time of this inspection, all specialist equipment we checked was in date and compliant across the hospital. We saw evidence that staff carried out regular safety checks of this specialist equipment.

Staff disposed of clinical waste safely. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed appropriate waste segregation procedures. Sharps bins were available and disposed of appropriately.

In theatres, there was a separate recovery area for children, in line with Guidelines for the Provision of Anaesthetic Services (GPAS) 2015.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. However, there were some issues with the completion of the Paediatric Early Warning Score (PEWS) and children’s site practitioners could not provide 24-hour cover due to vacancies within the team. There was lack of pre-operative assessment processes for children in place for before the day of surgery.

In the CQC Children and Young People’s Survey 2016 the trust scored about the same as other trusts for all three questions relating to assessing and responding to patient risk:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
</tbody>
</table>
20  Were the different members of staff caring for and treating your child aware of their medical history?  
   0-15 adults  7.72  About the same as other trusts  
36  Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?  
   0-15 adults  9.50  About the same as other trusts  

(Source: CQC Children and Young People’s Survey 2016)

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The trust used the Paediatric Early Warning Score (PEWS). Regular nursing checks such as temperature, blood pressure and heart rate were completed in line with this national scoring system. However, we noted in records that some children who were on hourly observations had not had all scores documented at hourly intervals. There were three missed hourly checks in records we examined. We were told this could sometimes happen at busy times but that all patients who were at high risk of deterioration were closely monitored. The paediatric safety thermometer data collected between July and October 2019 also showed some inconsistencies with PEWS being recorded and escalated appropriately. For example, in October 2019 33.3% of children had a completed PEWS that should have triggered escalation, but this had not been recorded. We did not see any incidences of PEWS that should have been escalated but were not in the 14 records we checked for this during the course of our inspection.

Although no high dependency care was offered at the hospital, some lower acuity children could be managed safely here or transferred to Queen’s hospital if more enhanced care was required. The children’s site practitioners (CSPs) helped ward staff in managing children with more complex needs, reviewing them and supporting them as needed. The CSPs spent a majority of their time at Queen’s hospital but started their shifts at Clover ward to ensure they were aware of any potential issues. The CSP team was made up of nursing staff with a background in paediatric intensive or high dependency care and aimed to provide a 24-hour service. However, the team was not fully established at the time of inspection, with only three whole time equivalent (WTE) posts filled out of an establishment of 5.3 WTE. This meant that nights were not always covered, as the CSPs tried to cover the day shifts as they also had a key role in bed management, patient flow and assessment at admission. On night shifts which were not covered by CSPs, the ward staff relied on medical staff to escalate any concerns about children, but medical staffing cover was sometimes stretched. Please see the medical staffing section of the report for details.

At the time of the last inspection, the hospital was unable to guarantee that staff involved in managing a deteriorating child would be appropriately trained. We found there was a lack of Paediatric Intermediate Life Support (PILS), Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) training for theatre staff who may be involved in paediatric deterioration. At the time of this inspection, we found that this had been added to the divisional risk register. Level two paediatric life support training had been provided to 94.6% of theatre staff, with three staff non-compliant. Of these, two had been booked to attend training, and the other was on maternity leave.

Following inspection, we were provided with data for indicating that nursing staff compliance within the division stood at 92.5% for PILS training. Medical staff compliance rates with either APLS or EPLS training stood at 100% for consultants and GP trainees, 89% for registrars, but only 29% for foundation year junior doctors.
Staff completed risk assessments for each child and young person on admission using recognised tools and reviewed these regularly. A new care plan booklet had been introduced to ensure that risk assessments were carried out consistently. We saw that the ‘sepsis 6’ pathway was displayed prominently in the department and staff were able to describe how to escalate and care for children at risk of sepsis in a timely fashion.

There was an item on the divisional risk register relating to lack of pre-operative assessment processes for children. Mitigation for this risk was to ensure that all patient safety checks were completed on the day of admission, but we were not clear how this enabled blood tests and more complex investigations to be completed. An update to this risk in October 2019 indicated that a meeting was being arranged to discuss taking forward the pre-assessment of children prior to surgery, with various options being explored.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person’s mental health). Ward staff told us that the trust employed registered mental health nurses to care for children and young people where this was required. The department was undertaking a project that aimed to improve the assessment of risk of children with mental health needs in order to allow more consistent and timely transfer to the inpatient ward where appropriate. This was in line with the national focus on this driven by the establishment of the inpatient taskforce and independent oversight board by NHS England.

Theatre staff used the World Health Organisation (WHO) surgical safety checklist. The surgical safety checklist for patients was intended for use throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. We saw evidence that the use of this tool was audited, with scores ranging between 99% and 100% between June 2018 and May 2019.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep children and young people safe.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels, and gave bank and agency staff a full induction. However, at the time of inspection, staff felt that nursing skill mix was not always ideal, with a high proportion of newly qualified nurses and healthcare assistants.

The table below shows a summary of the nursing staffing metrics in children’s services at King George Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Nurse staffing rates within children's services at King George Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

Senior staff informed us that the vacancy rate for the division stood at 12% at the time of inspection, which was the lowest it had been for some time. Data provided following inspection indicated that there was a vacancy rate of 11.5% as of October 2019, with a total of 2.38 WTE posts vacant out of an establishment of 19.3 WTE nurses. There were ongoing recruitment attempts, with rolling adverts for any vacancies.

There was a rotation programme for newly registered nurses covering cross site inpatient areas, the neonatal intensive care unit (NICU) at Queen’s hospital and both paediatric emergency departments. The trust told us a registered nurse from Queen’s hospital was due to rotate to Clover ward at the beginning of the next calendar year.

The trust assured us that actions had been taken in response to high sickness rates, with senior staff working with human resources and occupational health to support staff to return to work.
At the time of inspection, the trust provided data that indicated that sickness rates had improved. In October 2019, the sickness rate was 4.5%, which was the second lowest monthly sickness rate since October 2018 (with June 2019 having 0% sickness).

There were a number of bank and agency nursing staff with reported hours at both sites which couldn’t be split down, these data are shown in the table above. These have been provided as these include staff working at King George Hospital.

The above bank and agency rates were analysed for the past 12 months and no indications of improvement, deterioration or change were identified.

<table>
<thead>
<tr>
<th>Children’s services annual staffing metrics</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average establishment</strong></td>
</tr>
<tr>
<td>Target</td>
<td>N/A</td>
</tr>
<tr>
<td>All staff</td>
<td>N/A</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>N/A</td>
</tr>
</tbody>
</table>
At the time of the last inspection, staffing on the ward allowed one member of staff to every five children. At the time of this inspection, staffing levels had been adjusted to allow one member of staff for every four children and young people. This meant that during the day, there were four trained nurses on each shift (including one supernumerary nurse in charge) and one band three healthcare assistant (HCA). At night, there were two registered nurses and one HCA.

The band three HCA role had been introduced since our last inspection to allow them to take on the care of children and young people with lower risk. We were told that the introduction of this role had caused some issues at the stage of implementation, but that most issues had been resolved. However, registered nursing staff reported some strain at times when they had to care for higher dependency children and were still responsible for the giving of medication for the four children managed by the HCA.

Staffing ratios and skill mix were reviewed and adjusted using the Safer Nursing Care Tool (SNCT) to measure acuity and dependency of children. Daily cross site bed meetings took place to ensure that all paediatric areas were safely staffed across the site, with the children’s site practitioners (CSPs) taking an active role in the process. Staffing was adjusted across sites, with a nurse from Queen’s hospital present on the first day of inspection to cover the ward whilst a day case urology surgery list ran. However, nursing staff told us that they would often be asked to cover shortfalls at the Queen’s site and could be asked to help in the paediatric emergency department, especially out of hours. There was a feeling that staffing had improved but newly qualified nursing staff made up a significant proportion of the nursing workforce at the time of inspection. Staff told us that skill mix was sometimes not ideal, with a high proportion of newly qualified nurses and healthcare assistants on some shifts. Following our inspection, the trust told us Clover ward had a clinical establishment of 19.3 whole time equivalent staff. This included two newly qualified nurses equating to 10% of the workforce.

The trust provided further information in relation to safe staffing, noting that the CSP team started their out of hours shifts on Clover ward to ensure that the acuity of children was assessed, and staff felt confident in the management of the children on the ward. The asthma clinical nurse specialist (CNS) was also currently based on the ward to assist with any children requiring their support. The interim lead nurse also worked alternate days on the ward to ensure support and visibility.

Medical staffing

Although the service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm, at the time of inspection, the level of medical cover was variable. However, a business case for 10 new consultant posts and six new registrar level posts had been agreed and these posts were being recruited into. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The table below shows a summary of the medical staffing metrics in children’s services at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Children’s services annual staffing metrics</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
Monthly vacancy rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019. This could be an indicator of change. Additionally, for a portion of the period vacancy rates were reported as below 0% which would indicate staff were over established.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

In March 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 56 whole time equivalent staff working in services for children and young people at Barking, Havering and Redbridge University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>49%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
In the case of a medical emergency, paediatric consultants could be accessed 24 hours a day. Between Monday and Friday, there was a consultant available between 8:30am and 5pm. Outside of these hours, there was a resident consultant on call between 5pm and 7pm, and a non-resident consultant on call between 7pm and 8.30am. Over the weekend, there was consultant cover for both sites from 8:30am and 1pm, with non-resident consultant cover outside of these hours. During times when consultants are non-resident, they were available to come back on site at any time. Feedback from staff indicated that the current consultant rota was onerous, with one in six weeks spent covering an inpatient ward, where complex case management often meant little time for anything else. In the 14 sets of notes we reviewed for this purpose, we saw that every child was seen by a consultant paediatrician within 14 hours of admission.

In addition, there was also senior registrar and staff grade doctors covering the service. During the winter, there were two registrars covering both sites out of hours (but only one on site during summer months). However, we saw significant gaps in the rota for registrar grade staff and were told that this was an issue. Staff told us that medical cover on the ward was sometimes variable, especially out of hours, when the resident registrar medical staff could be needed in the paediatric emergency department. Nursing staff told us that they were always able to call for urgent help with children but sometimes had to send staff with non-urgent requests to the emergency department in order to get medication prescribed, for example.

Until October 2019, there had been an item on the divisional risk register relating to the medical establishment for paediatrics. As a result of this risk, the department had successfully had a business case agreed for 10 new consultant level posts and six registrar level posts. The trust had decided to recruit into these posts using a phased approach, with the recruitment of five consultants in 2019/20 and the remaining five posts to be filled in 2020/21. Following inspection, the trust confirmed that three consultants had been offered fixed term locum positions, with the intention of making them substantive if they proved to be the right fit. The remaining two posts were out for interview, with the intention of recruiting consultants with sub-specialist interests in cardiology and neurology. The trust hoped to attract more consultants with a sub-specialty focus to allow better management of clinics and patients across sites. The increased medical workforce would allow consultants to focus on developing the service to better meet the needs of children across the region.

With respect to the registrar posts, the trust had 10 posts to fill at the time of our inspection. This included the six new posts, and a further three existing vacant posts, as well as one maternity leave post. The trust held interviews in October 2019, with six successful appointments due to commence in January 2020.

The recruitment into these posts and increase in establishment would increase the consultant presence in the evening and at the weekend, and allow for a second registrar on site every evening, not just in the winter months. The risk on the divisional risk register relating to insufficient medical establishment funding had been closed on 2 October 2019.

Records

Staff kept detailed records of children and young people's care and treatment. The majority of records were clear, up to date, stored securely and easily available to all staff providing care. However, there were minor inconsistencies in documentation and the paper-based notes
could sometimes be hard to track and locate. There was a backlog of non-urgent clinic letters waiting to be sent to children’s GPs.

Paper-based notes were used across the department. These were stored in a lockable trolley located near the nursing station. These were not always kept locked as staff were always in this area, but we were informed that they would be locked at quieter times.

At the time of the last inspection, there were some issues with retrieving and tracking the paper-based notes. Staff reported that this had improved across the hospital, but notes could sometimes go missing on the ward for long periods, meaning entries had to added retrospectively, and the giving of medicines could sometimes be delayed. The nature of the records sometimes meant that sheets could be misfiled, or sheets could fall out of the notes.

Since our last inspection, a new admission document had been rolled out across the department in order to streamline the process and achieve consistency in terms of paperwork and risk assessments. In the six records we looked at in depth, we saw that five of these contained this admission booklet. Of these five, most assessments and care plans had been filled out, but there remained some inconsistencies and omissions.

Medical notes were generally completed to a high-standard and detailed the plan for the child or young person going forward. However, whilst all notes were signed and dated, there was often no record of the job role of the member of staff or the time the notes were completed. Some entries by medical staff were illegible.

Monthly documentation audits took place, with results discussed in the safety huddles and team meetings to drive improvement.

An item on the risk register indicated that there were some issues with transcribed letters not being sent to patients’ GPs, due to letter authors not approving them and letters not being flagged as being outstanding. There was a backlog of paediatric clinic letters that had not been typed. Senior staff informed us that this risk was being constantly reviewed and managed, with only non-urgent letters being delayed, as those classed as ‘urgent’ being prioritised and sent out separately. The division had successfully recruited a new service manager and patient pathway supervisor. Following these appointments, additional support had been agreed to manage these backlogs, with agreed protected time being given for typing of letters to each patient pathway coordinator, and additional typing support agreed from the operational improvement team.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines. However, some medicines were not always given in a timely manner and delays in the preparation of take-home medicines could sometimes delay the discharge of children.

Medicines were prescribed, stored and administered to people in line with current legislation and national guidance such as the National Institute for Health and Care Excellence (NICE). Staff followed current national practice to check children and young people had the correct medicines and provided specific advice to children and their families about their medicines. We viewed eight prescription records and found that allergies were flagged, which gave clear information to all members of staff working with those children who had reported allergies. Prescribed regular medication included the prescriber’s signature, the dose and frequency of the medication. All medicines were reviewed regularly, and prescriptions were checked by a pharmacist to ensure accuracy. However, we noted that some non-critical medicines had been given at a later time and
that in one case, salbutamol had not been signed as being given on two occasions. We were told that this was due to the fact that some medicine charts went missing at times and that band three HCAs had to wait for a registered nurse to be free to give medicines to the children and young people that they were allocated.

Medicines were stored in locked cupboards and keys were held by a registered nurse. Controlled Drugs (CDs) were stored in a separately locked cupboard, with a separate log book. CD stock levels were checked daily by two nurses, as per policy. The ward conducted quarterly audits into the safe storage and administration of CDs to ensure standards were met.

Staff followed guidance on how to monitor medication fridge temperatures. We saw that staff had taken appropriate action when temperatures were recorded outside of the required range.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

We noted that the risk register contained an entry relating to the lack of senior pharmacists within the division trust wide. Although staff told us that there was a pharmacist allocated to Clover ward, we were told this could sometimes cause delays in the preparation of take-home medicines. This was not currently audited, so we were unable to quantify the issue but most of the staff that we spoke to reported this as an issue. There had been an incident relating to the discharge of a child where a medicine had been incorrectly labelled as ‘do not take home’ and as this could not be rectified, the child had to stay in hospital an extra night.

The most common theme for reported incidents in the department was medication, with a total of 48 reported on the ward between November 2018 and October 2019.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support, although knowledge of duty of candour was variable amongst staff. Managers ensured that actions from patient safety alerts were implemented and monitored.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2018 to May 2019, the trust reported no never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) which met the reporting criteria set by NHS England from May 2018 to June 2019. Neither of these occurred on Clover ward.

(Source: Strategic Executive Information System (STEIS))

At the time of the last inspection, we found that there was not an open culture in relation to the reporting of incidents and that staff were not always logging incidents. At the time of this inspection, we found that this had improved significantly. Staff knew what incidents to report and how to report
Incidents were reported using the trust’s electronic recording system. Staff we spoke with knew how to report incidents and were aware of the types of incidents they needed to escalate. Staff told us that they were encouraged to report incidents.

Between November 2018 and October 2019, a total of 122 incidents were reported on Clover ward. Of these, none were recorded as ‘catastrophic’, ‘severe’ or ‘moderate’ harm. The majority caused no harm (102), with 13 causing ‘low’ harm and seven near misses. The main themes of these incidents were: medication (48), clinical care (23) and workforce (12).

Staff were able to tell us about recent incidents, including SIs, that had occurred and changes that had taken place as a result. Staff told us they received feedback on local incidents through daily ‘safety huddles’ and handovers, where they met as a team to discuss the feedback and look at improvements to patient care. Examples of changes in practice included changing the colour of the handover sheet after discovery in public of one with confidential information on it, and the revision of a policy to ensure frequent attenders were reviewed.

Between April and October 2019, no child deaths occurred on Clover ward. There were processes in place for the transfer of deteriorating children and young people to Queen’s hospital, and trust wide policies and processes relating to paediatric end of life care.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This means providers must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff we spoke to on inspection had a variable knowledge of duty of candour. The trust did not provide specific training in this area. Between May 2018 and April 2019, duty of candour was applied six times in the division, but none of these were on Clover ward.

There was a backlog of serious case reviews relating to outpatient appointment delays that affected some paediatric patients within the department. Please see the well led and outpatient reports for full details.

**Safety Thermometer**

The service used monitoring results well to improve safety. Staff collected safety information.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm and no new urinary tract infections in patients with a catheter from May 2018 to May 2019 for children’s services.

*(Source: NHS Digital)*

The service had started using a paediatric safety thermometer a few months before our inspection. They were not yet displaying this information in the ward as they were waiting for six months of data.
to be available. However, data collected between July and October 2019 indicated that no children had a pressure ulcer or moisture lesion (new or old), or extravasations in the 24 hours before data was collected.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice on the whole, with only four guidelines remaining out of date at the time of inspection. Managers checked to make sure staff followed guidance.

We saw that an item on the divisional risk register related to clinical guidelines for children services being out of date, which could potentially lead to staff following outdated practice guidance. The division had taken actions to rectify this and we were told that only four paediatric guidelines remained for review and final sign off at the time of our inspection. The escalation of all out of date policies was made directly to policy owners and the quality governance steering group. A new pathway and procedures approval group provided enhanced oversight of this process and met monthly to review and ratify all trust policies. In addition, there was a National Institute for Health and Care Excellence (NICE) compliance group led by the associate medical director to ensure that the trust's compliance status with NICE guidance was identified and verified.

We saw on inspection that staff followed treatment guidelines based on NICE guidance. Staff were able to access trust policies and procedures on the trust intranet.

The trust held a monthly clinical outcomes and effectiveness group meeting, chaired by the associate medical director. Senior clinical and nursing staff met to review the results of clinical audits, updates to guidelines and patient outcomes.

We saw that staff received support to care for children detained under the Mental Health Act (1983), with registered mental health nurses employed by the trust to help to care for these children and young people on the ward. At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

In the 2018 Patient-Led Assessments of the Care Environment (PLACE) survey, the hospital as a whole scored 93.5% for the overall food domain, against a national average of 90.2%. Ward food scored 95.6% against a national average of 90.5%.

At the time of the last inspection, there were concerns relating to the quality of food and lack of an assessment tool for assessing nutrition and hydration. At the time of this inspection, we saw that the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) was now in use to monitor children and young people at risk of malnutrition. We saw evidence of this used appropriately in the records we looked at, with care plans being put into place where concerns were identified. The use of STAMP was now audited on a monthly basis, with 10 records being examined per month on the ward. Between July and September 2019, results showed that only two out of the 30 children selected had not been assessed using STAMP within 24 hours of admission.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. There was a nutrition board on the ward which
highlighted any special dietary needs for children and young people, including religious, cultural and other needs. Children and families we spoke to were happy with the provision and choice of food. Staff fully and accurately completed children and young people’s fluid and nutrition charts where needed.

Specialist support from staff such as dietitians and speech and language therapists (SALTs) was available for children and young people who needed it. There was one paediatric SALT based mainly at Queen’s hospital, with support provided to Clover ward on request. In the 12 months prior to our inspection, three referrals had been received from Clover ward.

**Pain relief**

Staff assessed and monitored children and young people regularly to see if they were in pain, and usually gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. However, pain relief could sometimes be delayed in administration where children were allocated to band three healthcare assistants, if the registered nurses were busy managing more complex children.

Staff assessed children and young people’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Those with communication difficulties were able to access modified pain assessment tools. Children and young people usually received pain relief soon after requesting it. Families that we spoke with were happy that their child’s pain was well controlled. Staff prescribed, administered and recorded pain relief accurately. We saw examples in the records of pain control managed with PRN (pro re nata or as required) analgesia. We were told some PRN pain relief could sometimes be delayed in administration where children were allocated to band three healthcare assistants, if the registered nurses were busy managing more complex children.

There was access to a play specialist during the week who could help with distraction techniques and support children undergoing potentially painful procedures.

The trust had a dedicated acute pain service, who offered advice and support to patients who were experiencing pain as a result of their treatment or illness. However, there was still no dedicated paediatric input within this team, who were focused on the needs of adults.

The new trust pain guideline for children was due to be ratified in early 2020. Once this was introduced, the trust planned to introduce an audit schedule for pain relief in children. Paediatric safety thermometer data collected between July and October 2019 indicated that the proportion of children in pain at the time of the survey collection usually stood at 0%, apart from in October 2019, when this constituted 8.3% of children asked.

**Patient outcomes**

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

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Improvements were checked and monitored.

The table below summarises Barking, Havering and Redbridge University Hospitals NHS Trust
In response to this audit, the trust recognised the need to improve the median HbA1c score further. They had focused on following up children who did not attend clinic appointments, improving documentation and improving the number of children with continuous glucose monitors, which reduced the risk of recurrent hypoglycaemia. This had improved to nearly 30% of the children being seen in May 2019, but this was still a little short of the national average of 35.7%. Further improvements still needed to be made, including a business case that needed to be submitted for additional psychology sessions to support these children.

An audit of 79 children with asthma was conducted across both sites between September and December 2018. Results showed that acute management of asthma was very good, but that early prevention, education and management needed to be improved, as well as documentation and treatment planning. As a result of this audit, plus learning from recent serious incidents, three clinical nurse specialists in asthma were appointed within the trust to help drive education and prevention in this patient group. An educational leaflet and asthma discharge checklist were also drafted.

Other audits were conducted within the division in order to identify possible improvements in care. These included compliance with intravenous fluid therapy guidelines for children and the management of fever in children under five years against NICE quality standards.

From February 2018 to January 2019 there were no specialties with more than six readmissions following an elective admission for both the under 1 and 1 to 17 age groups.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from February 2018 to January 2019 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average for paediatrics.
For patients aged 1-17 years old, there was a lower percentage of patients readmitted following an emergency admission compared to the England average for paediatrics, a similar percentage of readmitted following an emergency admission compared to the England average for general surgery, and a higher percentage of patients readmitted following an emergency admission compared to the England average for general medicine.

**Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2018 to January 2019)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Barking, Havering and Redbridge University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.4%</td>
<td>1,233</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

**Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2018 to January 2019)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Barking, Havering and Redbridge University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.9%</td>
<td>3,312</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4.1%</td>
<td>389</td>
</tr>
<tr>
<td>General Medicine</td>
<td>7.3%</td>
<td>124</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

From March 2018 to February 2019 there were less than six patients aged under one admitted therefore data were suppressed.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse than the England average for epilepsy. For diabetes there were less than six readmissions therefore data were suppressed.

**Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (March 2018 to February 2019)**

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Barking, Havering and Redbridge University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>18.5%</td>
<td>233</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>45</td>
</tr>
<tr>
<td>Diabetes</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>17.5%</td>
<td>57</td>
</tr>
</tbody>
</table>

Notes: To protect patient confidentiality, figures between 1 and 5 and their associated proportions have been suppressed and replaced with “*” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional
number (generally the next smallest) has also been suppressed. The “-” (a hyphen) in the table indicates that there were no admissions for these long-term condition or age groups.

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their roles. Managers appraised most staff’s work performance and held supervision meetings with them to provide support and development. However, results from the General Medical Council survey for doctors in training (2019) fell below expectation. Some staff indicated that access to continuous professional development (CPD) was restricted due to the trust being in financial special measures.

There were arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. We received positive feedback from new starters in relation to induction processes.

From April 2018 to March 2019, 74.9% of staff within children’s services at the trust received an appraisal compared to a trust target of 90%. For the year-to-date period April 2019 to June 2019, 3.1% of staff had received an appraisal. Data submitted by the trust following inspection showed that compliance had improved to 87.4% of staff having been appraised. This remained a focus of the division.

From April 2018 to March 2019, at King George Hospital, 57.9% of staff within children’s services at received an appraisal compared to a trust target of 90%. At the time of inspection, senior staff told us that everyone apart from new starters had received an appraisal.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>11</td>
<td>19</td>
<td>57.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

No data was provided in relation to the appraisal of medical staff within the division.

The clinical educators supported the learning and development needs of staff. Staff indicated that access to continuous professional development (CPD) was restricted due to the trust being in financial special measures. Some staff had been able to access in-house training programmes, but others felt restricted in terms of access to CPD.

Staff had received specific training to understand the additional needs of people with mental health conditions, a learning disability or autism.

In the most recent General Medical Council (GMC) survey for doctors in training (2019), the trust did not perform well. A total of seven red flags had been reported in relation to: overall satisfaction (69.8, falling from 77.3 the previous year), clinical supervision out of hours (80, falling from 89.6 the previous year), reporting systems (63.7, falling from 73.3 the previous year), supportive environment
(61.5, falling from 74.4 the previous year), educational governance (59.8, falling from 76.9 the previous year), local teaching (54.7, falling from 64.8 the previous year), and study leave (32.2, falling from 48 the previous year). The trust told us they were in the process of meeting with doctors in training to understand these results, but suspected it was related to the depleted medical workforce, which left little time for reflection and teaching. They hoped that the business case that had been agreed for consultant and registrar posts would improve the experience of junior doctors. In addition, they were looking at ways to improve teaching facilities and ways of teaching. We saw a copy of a detailed action plan that had been sent to the GMC by the trust.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care. However, there was limited provision for children who required occupational therapy or physiotherapy services.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.54 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

*Source: CQC Children and Young People’s Survey 2016*

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. We observed good team working between all grades of staff. Staff told us that there were positive working relationships between all individuals at the service, with a strong nursing team who felt able to challenge doctors. Doctors felt well supported by the nursing team, including the children’s site practitioners.

At the time of the last inspection, we found there were limited services for children who required occupational therapy or physiotherapy services. At the time of this inspection, we found that this was still the case. Staff told us there was a paediatric physiotherapist who worked at Queen’s hospital who attended the site for two days a month, but that cover at other times was not always good. When staff on Clover ward needed advice, they could contact the paediatric physiotherapist. Staff informed us that where a paediatric patient had a respiratory issue requiring physiotherapy input, the staff could bleep one of the surgical physiotherapists who would come and administer the therapy. Between November 2018 and October 2019, there had been a total of 15 paediatric physiotherapy referrals received from Clover ward. Five of these referrals were handled by orthopaedic physiotherapists, five were seen by surgical physiotherapists, three were seen by the neurology physiotherapy team, and two were seen by the paediatric physiotherapist. None of the four physiotherapists we spoke to over the course of the inspection had worked with children. There was no access to paediatric occupational therapists for children at the trust at the time of inspection. The trust told us that urgent requests could be covered by the adult occupational therapy requests with input from the paediatric physiotherapist, with all other referrals made to appropriate community teams.

There was access to qualified play specialists available five days a week, between 9am and 5pm, on the ward at the time of inspection. Across the division, there were 2.2 whole time equivalent (WTE) play specialists against an establishment of 2.6 WTE, with one full-time member of staff and two part-time staff. They worked across sites on a rotation. Another 0.4 WTE post was out to advert at the time of inspection. In addition, 1.4 WTE play workers worked across sites. They told us that they could accompany children to imaging or theatres should this be needed.
Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The children's outpatient service was open 8.30am to 6.30pm Monday to Thursday. It was occasionally open on Fridays if patient demand was high and staff were available.

Health Promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the ward and in the outpatient department. We saw a health promotion board with information on topics such as asthma and keeping out of the sun in the outpatient waiting room. There was a range of patient information available for children and families, including some in easy-read format.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle. This included the tailoring of meal plans for those children at risk of being overweight.

There was access to a range of clinical nurse specialists (CNSs) for advice on specialist areas such as diabetes, epilepsy and oncology. Three asthma CNSs had recently been recruited to improve the care of children with this condition due to serious incidents that had occurred recently. This service was currently in development, with the aim of doing more prevention work within the community once it was established in the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

At the time of the last inspection, we found that staff were not fully aware of the ward’s policy for consent. At the time of this inspection, all staff were able to tell us how they would ensure children and their families consented to their care, including those under 16 who were deemed to have ‘Gillick competence’. Staff understood Gillick Competence and supported children who were able to, and wished to make, decisions about their treatment. Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff clearly recorded consent in the children and young people's records.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions.
The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>58</td>
<td>67</td>
</tr>
</tbody>
</table>

In children’s services there was no requirement for medical staff to undertake this training, in accordance with the Intercollegiate Document for Adult Safeguarding Roles and Competencies for Health Care Staff’ (August 2018).

A breakdown of compliance for MCA/DOLS training courses from April 2019 to June 2019 at King George Hospital for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

In children’s services the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DoLS training from April 2019 to June 2019 for qualified nursing staff in children’s services that work across both sites is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards</td>
<td>30</td>
<td>31</td>
</tr>
</tbody>
</table>

Qualified nursing staff in children’s services working across both sites, met the target for completion of MCA/DoLS training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust performed worse than other trusts for one question and about the same as other trusts for the remaining four questions relating to the effective domain in the CQC Children and Young People’s Survey 2016.

The question where the trust performed worse than other trusts was about taking care of a patient’s special needs.

CQC Children’s Survey questions, effective domain, Barking, Havering and Redbridge University Hospitals NHS Trust
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>7.80</td>
<td>Worse than other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.27</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.36</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>6.78</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>4.68</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)
Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. We observed staff whilst they provided care and support. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Children, young people and their families said staff treated them well and with kindness. We spoke to five children and relatives. They were consistently positive about the care they had received. One parent told us that the care was “excellent” and “more personal” than at other hospitals they had been to. Another parent told us that staff were both “professional” and “friendly”.

We were shown a cupboard full of presents that could be given to children on special occasions or after they had been brave. For example, one child had undergone a particularly stressful intramuscular injection and a nurse gave them a soft toy from the cupboard. These presents had been donated or bought with funds raised by the charity.

In the 2018 Patient-Led Assessments of the Care Environment (PLACE) survey, the hospital as a whole scored 77.5% for the privacy, dignity and wellbeing domain, against a national average of 84.2%. However, we did not find any evidence that privacy and dignity were not maintained on our inspection. Staff followed policy to keep care and treatment confidential. For example, we observed staff closing curtains while undertaking physical care or examinations.

Staff understood and respected the individual needs of each child and showed understanding and a non-judgmental attitude when caring for or discussing children with mental health needs. Staff had received specific training to understand the additional needs of children with mental health conditions, a learning disability or autism.

The Friends and Family Test (FFT) was used across the trust to gather feedback from patients so they could give comments on their experiences and state whether they would recommend the service. Child-friendly survey formats were available. Between January and April 2019, response rates varied between 37.9% and 52.5%, with overall positive scores of between 94.1% and 95.9%. Between April and October 2019, response rates varied between 74.5% and 108.8% (with more than one relative filling out feedback), with overall positive scores falling between 92.2% and 97.2%.

The trust performed worse than other trusts for one question and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

The question where the trust performed worse than other trusts was about how well patients were looked after in the hospital overall.

CQC Children and Young People’s Survey 2016 questions, compassionate care, Barking, Havering and Redbridge University Hospitals NHS Trust:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.61</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Parents we spoke to told us they felt confident leaving the ward and their child’s care with the staff on the ward. The play specialist gave multiple examples of supporting children when their parents could not be present for procedures. She also spoke about the support and reassurance she offered to parents and siblings.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. They were able to tell us how they would support children and their families at distressing times. The trust had recently rolled out ‘we can talk’ training for staff, which explored communication styles and ways to approach conversations, as well as common mental health difficulties. Data indicated that 15 staff at the hospital had attended this training at the time of our inspection.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family's, wellbeing. We saw that social and psychological needs were discussed during handovers and considered in care records. Children with any complex emotional needs would be discussed in the weekly psychosocial meetings, where a representative from the crisis team for children attended. There was access to a children’s psychologist for some specialisms, such as diabetes and haemoglobin disorders. Parents needing emotional support were supported through chaplaincy services.

Staff were able to describe how they would support children experiencing mental health problems on the ward, with the support of a registered mental health nurse. The interim lead nurse was undertaking a project that looked into the pathway for children experiencing mental health conditions presenting at the paediatric emergency department, to see whether a formalised risk assessment would allow for them to be cared for on the ward. This was in line with the national focus on this
driven by the establishment of the inpatient taskforce and independent oversight board by NHS England.

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, Barking, Havering and Redbridge University Hospitals NHS Trust:**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.09</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.20</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.33</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.49</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.00</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)

**Understanding and involvement of patients and those close to them**

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Staff talked with children, young people and their families in a way they could understand, using communication aids or an interpreter where necessary. We saw examples of information provided in a child friendly format to help children make decisions about or agree to care and treatment.

Staff supported children, young people and their families to make informed decisions about their care. We reviewed six sets of records for children receiving care on Clover ward. The records showed that discussions took place between clinicians and children, where appropriate, and with their parents, before any interventions or treatment took place. Staff confirmed that older children could request to speak to them without their parents present if they wished.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.

The trust performed worse than other trusts for one question (about whether staff explained to patients how well operations or procedures had gone) and about the same as other trusts for the remaining 19 applicable questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.
There was no score for question 66 ‘If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?’.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Barking, Havering and Redbridge University Hospitals NHS Trust:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.81</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>8.18</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.97</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.46</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.31</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.72</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.37</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.27</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>7.96</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>8.81</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>8.29</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.01</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.71</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>6.85</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Score</td>
<td>Score Range</td>
<td>Note</td>
<td>Source</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>66</td>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 CYP</td>
<td>9.21</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 CYP</td>
<td>7.09</td>
<td>Worse than other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>72</td>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 CYP</td>
<td>7.87</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016)
Is the service responsive?

**Service delivery to meet the needs of local people**

The service worked with others in the wider system and local organisations to plan care. It planned and provided care in a way that met the needs of some local people and the communities served. However, there were no provision or adjustments regarding the care of adolescents on the ward and in children being seen in other areas of the hospital. There was no schooling provision on Clover ward, with individual provision being made for children of school age. The did not attend (DNA) rate for children being seen on an outpatient basis was higher than the national average.

Divisional leaders were able to tell us about how they planned and commissioned services as part of a wider system. A regional approach was taken to deciding what paediatric services were available at the hospital sites in the trust. The divisional leaders were members or chairs of several groups and committees across the region, including the asthma network and healthy London partnership, amongst others.

There were facilities available for parents and relatives on Clover ward. There was a dedicated room for parents with facilities to make hot drinks and prepare food. This room was for the use of adults only, with no siblings or children allowed. Ward staff told us they reminded families of this due to the presence of the hot drink making facilities, which could be a danger for children.

An item on the divisional risk register related to children under the age of 16 who may not receive treatment in an environment that is appropriate for their needs. This was a long-standing issue for the trust and remained on space allocation list. It was noted that it was unlikely to receive capital funding in 2019/20 due to limited available funding. On inspection, we visited other areas of the hospital and found that although there was a dedicated recovery bay for children, this was located so that children would have to pass adults on their way there and back.

In the imaging department, there were two rooms used for performing ultrasounds on children, but they were not decorated in a child-friendly way. There was no separate waiting area or toys for children. There was a paediatric area in the MRI scanning department, but staff told us that children rarely came for MRIs here, instead being seen at Queen’s hospital.

At the time of the previous inspection, we found issues with children being seen in the phlebotomy department of the hospital. At the time of this inspection, we found that this had improved slightly, with children under five being seen at Queen’s for bloods to be taken. Children between five and 12 years old given booked appointments. There was a separate waiting area for these children, with a limited number of toys and booked. All children over the age of 12 were not prioritised and had to wait in the adult area. As these children were not given any priority, they may have waited several hours before being seen.

At the time of the last inspection, we noted there were no teaching facilities for long-term stay children of school age. Teaching services had been removed because the hospital was deemed to be for short-stay patients. This still remained the case. The trust told us that length of stay on the children’s wards was low enough that it had been agreed with the local boroughs that no teacher would be hosted on Clover ward (one day of teaching per week was provided on the inpatient ward at Queen’s hospital). Data provided by the trust for the period between November 2018 to October 2019 showed that the average length of stay was 1.7 days, with nine episodes of care totalling 10 days or longer. Six of these children who stayed longer than 10 days were of school age. Where clinically appropriate, individual arrangements could be made for children and young people with
their schools to enable either partial attendance or to receive school work to complete. Staff confirmed that this happened in some cases.

Children under 16 were not admitted to wards outside of Clover ward at the hospital. We found that there was no separate area or specialised provision for adolescents on Clover ward, with staff telling us that they would cohort any older children together where possible in bay one, which was furthest away from where babies may be being cared for in side rooms. Staff reported that a lot of older children were coming in for day surgery rather than inpatient care, and that they always checked they were comfortable with where they were looked after in the ward.

There was a standard operating procedure for the admission of 16-18-year olds to adult inpatient wards, as well as a transition policy. These described the way in which the ways of young adults would be met and the process of preparing and moving from children's to adult health care. Support for young adults with complex needs transitioning into adult care was provided by the children’s advisor in learning disability and autism. The interim lead nurse had been tasked with focusing on a project looking at transitional care for young adults in some specialties, in line with the national focus on this driven by the establishment of the inpatient taskforce and independent oversight board by NHS England.

Managers ensured that children, young people and their families who did not attend appointments at the children’s outpatient department were contacted. Parents whose children were attending outpatient appointments were sent a text message seven days in advance of their appointment, as well as a 48-hour reminder text. They were able to cancel and rebook their appointments by responding to the first text message. Between April and October 2019, the did not attend (DNA) rate for new children seen in general paediatric clinics within the trust was approximately 16%, and 24% for follow-up appointments. In the same period, this stood at 22.2% for new children in paediatric diabetic medicine, and 21% for follow-up appointments. This was higher than the national average.

The trust performed better than other trusts for one question (about whether patients were always treated on a children’s ward) and about the same as other trusts for the remaining 16 applicable questions relating to the responsive domain in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, responsive domain, Barking, Havering and Redbridge University Hospitals NHS Trust:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>10.00</td>
<td>Better than other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.83</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.39</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.35</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>7.84</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
</tbody>
</table>
### Meeting people’s individual needs

The service was inclusive and took account of most children, young people and their families’ individual needs and preferences. Staff made reasonable adjustments to help most children, young people and their families access services. They coordinated care with other services and providers. However, there was still limited support available for those with mental health needs.

At the time of our last inspection, we found there were limited resources available for children with mental health needs and limited access to child psychotherapy support. At the time of this inspection, the access to psychotherapy support had not improved for most children, although there was support available to some children who attended the outpatient department with certain conditions. No children were admitted to Clover ward solely for mental health needs. These children only came to the ward if they were physically unwell and required medical intervention. If a child with mental health needs were medically fit and still requiring a mental health bed, they would be kept on Clover ward until a bed had been allocated in an appropriate unit. Staff felt well supported in caring for these children and young people on the ward and told us that the trust ensured registered mental health nurses were present at all times to support these children. There was a project led by the interim lead nurse (in tandem with work taking place nationally) to look at whether children awaiting mental health beds in the emergency department could be looked after on inpatient wards.

(Source: CQC Children and Young People’s Survey 2016)
In the 2018 Patient-Led Assessments of the Care Environment (PLACE) survey, the hospital as a whole scored 82% for the disability domain, against a national average of 84.2%. The inpatient ward and outpatient area were accessible for people using wheelchairs. We saw that there was a statement in appointment letters which encouraged parents to contact the outpatient department or ward in advance of their appointment to tell them about any needs in order that they could accommodate these.

Staff supported children and young people living with complex health care needs by using ‘This is me’ documents and passports. We saw examples of these, as well as communication cards to support this aspect of these children’s care. The 22 cards depicted child friendly ‘wants’ for use in the hospital environment. They included photos and simple language to demonstrate interventions that may take place on the ward such as doctor examination, nursing observation and possible wants for a child such as to play, to use the toilet or to eat. Learning disability awareness training was provided at the trust induction training for all nurses and health care assistants. There was a children’s advisor in learning disability and autism who was able to support children with complex needs whilst they were in hospital. They were part of the wider learning disability support team. The trust had a specific admissions care pathway for people with a learning disability, and ward staff were required to notify the team of any admissions via email. Between April 2018 and March 2019, we saw that children’s advisor for learning disability and autism received 227 referrals for children with learning disabilities across the trust, of which 21 had been for children on Clover ward. Of the 227 children across the trust, 96.3% had access to a hospital passport, 91.8% of inpatients with a learning disability had a completed specific pathway to highlight individual needs and reasonable adjustments, and 100% of children had been flagged to the team.

A cumulative audit was conducted on nine children with learning disabilities using data collected between May to September 2019. This sought to find out whether the voice of children and young people who have difficulty expressing their wants and needs was being heard. Findings showed that 100% of children reported nursing and medical staff listened to them and explained care in a way they could understand. Most children (88.8%) and young people (77.7%) felt medical staff helped them to explain themselves and listened to them (88.8%). However, the audit found the use of hospital passports could be improved and recommended offering them on admission more routinely.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Both telephone and face to face interpretation was available, as well as sign language interpretation. Several staff of various grades - both doctors and nurses - were able to provide interpretation services in various languages. Whilst we did not see any information leaflets available in languages other than English, staff told us these could be requested if necessary.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. For example, halal, kosher and vegan food options were available, amongst other choices.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were not consistently in line with national standards.

Clover ward was for short-stay inpatients and children requiring day case surgery only. Between November 2018 and October 2019, the average length of stay for children on the ward was 1.7 days. In the same period, 23% of children and young people were day cases and 97% of children stayed
less than five days. Despite issues with the levels of medical staffing mentioned elsewhere in the report, we saw from records that each child admitted with an acute medical problem was seen by a middle-grade registrar within four hours of admission, and a consultant within 14 hours.

Clover ward was usually staffed for 12 children and young people, but we were informed that capacity could increase, usually during the winter months, when there was sufficient staffing to do so. The ward could flex up to either 14 or 16 beds if there were sufficient levels of staff available. Between 1 November 2018 and 1 November 2019, this had happened a total of 17 times. There was no formal policy or standard operating procedure to demonstrate how the flexing of beds from 12 to 16 was undertaken, as the trust reasoned this was not frequent enough to be required. Instead, this was monitored via the children’s site practitioner shift reports.

When children required surgery, they were placed first on operating lists and they would only be sent for when theatre was ready. A paediatric nurse attended the child and one parent was able to stay with them until they were anaesthetised. The paediatric nurse attended recovery when the child was awake and accompanied them back to the ward.

The service moved children and young people only when there was a clear medical reason or in their best interest. Between April 2018 and March 2019, a small number of children were moved from Clover ward. Out of a total of 1890 children and young people, 37 were moved once, four children were moved twice, and two children were moved more than four times. Four bed moves occurred at night (between 10pm and 8am). We asked senior staff about these figures and were informed that these were mainly due to children with higher levels of dependency being transferred to Queen’s hospital for more appropriate care.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. We saw evidence of discharge planning in the records we examined and in daily handovers. However, lack of access to occupational therapy and physiotherapy services could impact on discharge planning according to staff we spoke with. Delays with take-home medications mentioned elsewhere in the report could also cause delayed discharge.

The children outpatient department was open Monday through to Thursday, 8.30am until 6.30pm. It was open occasionally for urgent appointments on Fridays. The department was staffed by one healthcare assistant (HCA) or two if very busy. The doctor pressed a bell when they were ready to see children to call them into one of the two clinic rooms within the ward. Staff kept children and parents up to date if the clinic was running behind. There were a range of clinics available at the hospital, including: dermatology, general paediatrics, asthma, surgical, diabetes and endocrine issues. There were plans to increase capacity and the range of specialities offered in clinics in line with the recruitment of consultants that had been agreed.

Between June 2018 and May 2019, the average wait time children waiting for urgent appointments was 4.4 weeks, which exceeded the two-week target. In addition, the NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. This is referred to as the referral to treatment (RTT) standard. Where patients are seen on an outpatient basis and do not require an admission to hospital as an inpatient, this is referred to as the ‘non-admitted’ pathway. Between April and October 2019, between 89.2% and 95.5% of children from paediatric specialties on this non-admitted pathway were being seen within 18 weeks. None of these children had waited over 52 weeks. Across the trust, there were issues with meeting this standard, as well as a backlog of serious harm reviews that looked into cases where this standard had not been met. Since April 2018, a random sampling of 10% of the non-admitted pathway tracking list (PTL) of patients waiting
30 - 52 weeks showed that in 92% of cases, serious harm reviews had not been completed. Please see the outpatient and well led report for further discussion of this issue as a whole.

In addition, there was an item on the divisional risk register relating to paediatric hot clinics within the trust. These hot clinics were designed to provide an opportunity for GPs to contact a paediatric consultant to discuss a referral or seek advice about treatment options for sick children. The hot clinic was aimed at children who were not ill enough to be referred to the emergency department but who could not wait for a routine outpatient consultation. The average wait for children to be seen in a hot clinic was two weeks on average, which was well beyond the three-day target. This was due to the level of demand and no action had been agreed to reduce this.

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to resolve complaints informally where possible.

From April 2018 to March 2019, there were two complaints about children’s services at King George Hospital. The trust took an average of 25.5 days to investigate and close complaints, this was close to the target within the trust’s complaints policy, which states complaints should be answered within 25 days.

Both complaints were for care and treatment, with patients unhappy with treatment. Neither was upheld by the trust.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From May 2018 to April 2019 there were no compliments about children’s services at the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

At the time of our last inspection, we found that learning from complaints was not shared with staff across the division. At the time of this inspection, staff told us about recent complaints and learning that had taken place as a result. These would be shared in handovers, safety briefings and via email. This demonstrated managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used feedback to improve daily practice, including how one informal piece of feedback relating to a child with learning disabilities had made them consider how to make more reasonable adjustments for children with enhanced needs.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for most patients and staff, although some feedback indicated that the divisional leaders were
not always visible at this site. They supported staff to develop their skills and take on more senior roles.

The service sat in the women and child health division, with a divisional director, divisional manager and director of nursing. Below them sat the interim lead nurse (a six-month post initially with scope to be extended) and then the interim matron, who both worked cross site to manage children’s services. At local level, there was a band seven ward manager, but they were on sick leave at the time of inspection. The interim lead nurse role had been added as it was recognised that another layer of leadership may be required, and the lead nurse role was present in other divisions within the trust. The post was initially for six months to help with winter pressures and to focus on project work, with the post being extended if it could be shown to be of good value.

The service’s leadership team had good knowledge of the service, with a clear understanding of the risks and challenges the service faced. We saw that they were proactive in tackling issues and finding solutions, such as drafting the business case for the medical staff increase. They represented the division across the hospital and were keen to ensure sufficient priority was given to the division by the executive team. They supported staff to develop their skills and take on more senior roles, such as the interim management posts, which people had been promoted into from within the existing team.

The senior team demonstrated good leadership across the clinical areas, and most staff we spoke with on the wards recognised who they were. There was some feedback that the divisional leads tended to be less visible at King George hospital. The matron did frequent walkarounds to speak to staff directly and ensure they felt able to voice any concerns or ideas. They were based two days a week at this site, and three days at Queen’s hospital.

Staff told us they were well supported by their leadership team, who were open to new ideas and suggestions. Both medical and nursing staff felt they were involved in clinical decision making and they had ready access to senior staff when required. The leadership team told us they were proud of their staff who worked hard to deliver high quality care for children.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However, some staff felt that the hospital was forgotten or overlooked by senior staff at times.

The trust’s vision “to provide outstanding healthcare to our community, delivered with pride” was supported by five key values and behaviours. These had been developed by staff and were: passion, responsibility, innovation, drive and empowerment (known as PRIDE).

At the time of last inspection, we found that staff were not clear on the overall trust vision and values. At this inspection, we found that most staff were familiar with these and how they related to their role in the organisation.

The clinical services strategy from December 2016 provided by the trust proposed that King George Hospital became the centre of excellence for elective care, long term conditions and care of the elderly, whilst Queen’s Hospital became the centre of excellence for emergency, maternity and paediatric care. It noted that paediatrics was not yet centralised at Queen’s Hospital, although ‘blue light’ ambulances for children no longer attended King George Hospital and all emergency surgery
was undertaken at Queen’s Hospital. Staff at King George Hospital had mixed feelings about this strategy, with some feeling that the centralisation of services was positive and safer for children, and others feeling that it was important to retain paediatric services at both sites. Some staff we spoke to felt like King George Hospital was becoming less important in terms of paediatric care, with a sense of being forgotten or overlooked by senior staff at times.

The new clinical services strategy was being considered at the time of inspection but was not yet at the point of drafting. The divisional team stressed the importance of taking a systems wide approach to the planning of services, taking into account what other external stakeholders and neighbouring services needed from the hospital.

**Culture**

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

Service leads and managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were clearly committed to providing care to children. Overall, they felt valued by their managers and appreciated for how hard they worked. They were proud of the work their colleagues and department did.

Most staff told us they felt supported to develop their careers with the trust, although there were limited opportunities for external continuous professional development due to the financial position of the trust. In addition, the most recent General Medical Council (GMC) survey for doctors in training (2019) results were poor. However, there were examples of people who had been promoted within the organisation.

Staff in the department felt able to raise and discuss any concerns with their colleagues and managers, as appropriate. We observed a healthy environment where the multidisciplinary team felt able to challenge and share their thoughts or opinions with each other. Service leads dealt with any potential issues appropriately and swiftly. All staff we spoke with were able to tell us about incidents that had occurred recently and learning that had taken place as a result.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke to on inspection had a variable knowledge of duty of candour. The trust did not provide specific training in this area.

**Governance**

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

The divisional leadership team had regular team meetings, in which issues and general communications were shared and discussed. This then fed into the divisional operational board. This group then reported to the performance review panel, where any issues were then reported to the Trust Executive Committee (TEC) meeting, chaired by the chief executive. Senior divisional leaders
were satisfied that children’s services were getting a higher profile within the trust as they felt they continued to push for parity in this respect. The medical director was the named executive lead for children and young people. She chaired the children and young people’s group, which aimed to ensure a trust wide approach was taken to addressing the needs of this age group.

In terms of children’s safeguarding, the weekly psychosocial meetings fed into the wider safeguarding operational group, which then fed into the safeguarding strategic & assurance group. This meeting, plus any information from local safeguarding children boards, informed the quality governance steering group and the quality assurance committee. Any relevant safeguarding issues would then be reported to the board through this committee. We viewed a range of minutes from these meetings and were satisfied with the governance arrangements for the reporting of safeguarding issues to board level. Staff we spoke to were aware of the governance surrounding safeguarding and were able to tell us about recent concerns that had been raised within the trust. Staff at all levels were clear about their roles and understood what they are accountable for. They told us they had adequate opportunities to discuss issues affecting the service, in handovers and safety briefings, as well as team away days.

Management of risk, issues and performance

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

At the time of the previous inspection, we found that the divisional risk register had limited descriptions of controls and actions taken to address how any identified risks would be mitigated. Risks were not regularly reviewed, and the risks senior staff described to us did not correlate to those on the register. At the time of this inspection, we found that these issues had been resolved.

Senior leads told us that the main risks to the service at the time of inspection related to outdated paediatric guidelines, lack of storage space for echocardiogram images electronically, and gaps in medical staffing, nursing staffing and pharmacy support. This correlated to items on the divisional risk register provided. Details of each risk are included in the relevant sections of this report. Risks were added to the register in monthly meetings and staff were able to describe how they would raise a potential risk to be discussed at this meeting. Risks were graded, based on both the likelihood and severity. We saw evidence that risks were reviewed and updated each month.

There was a backlog of serious case reviews relating to outpatient appointment delays that affected some paediatric patients within the department. Please see the well led and outpatient reports for full details.

There was evidence that winter management plans specifically included services for children, with the interim lead nurse post being created partially to help manage this more difficult season. We saw an escalation plan had been drafted to address any potential capacity concerns within the division throughout the winter.

The service collated a range of information about their activity and was actively involved in meaningful audits. Improvements were identified as a result of these audits and action plans to improve service provision had been developed.
Information management

The service did not have effective systems and processes to provide assurance over the accuracy and completeness of data at a trust wide level. The information systems were not consistently integrated and secure. However, at a local level, leaders had access to a range of performance measures about quality, operations and finances, and used it to improve the service.

There were a number of issues relating to patient appointments and data quality across the trust which also affected paediatric patients, described in more detail in both the outpatient report and well led report. In addition, an item on the divisional risk register indicated that there were some issues with transcribed letters not being sent to patients’ GPs and a backlog of paediatric clinic letters that had not been typed. Actions had been taken to rectify this situation, but it remained an issue at the time of our inspection.

Another item on the risk register related to the lack of storage space for paediatric echocardiogram images electronically. This resulted in the consultant responsible for these investigations storing the images on video cassettes which were subsequently filed in his office. A description of the image and findings were documented in each set of notes at the time of each scan. When a child was severely unwell or transferred to another hospital, the image was stored onto a CD locally and then that CD was sent to radiology department who could upload the scan image. Funding to resolve this issue was still needed at the time of our inspection, so this remained a risk.

Earlier in 2019, a serious incident had occurred within the trust whereby handover documents from a children’s inpatient ward were found at a bus stop. The handover document contained confidential patient details, as well as clinical and safeguarding information. As a result, the trust had changed the colour of handover documents in an effort to remind staff to add them to confidential waste before they left work. Although 97.4% of nursing staff had completed information governance training at the time of our inspection, the completion rate for doctors varied between 71% and 88%, dependent on grade.

Locally, leaders had access to a range of performance measures about quality, operations and finances, and used it to improve the service. They regularly collated information and fed this back to the board and circulated it amongst staff throughout the trust.

Engagement

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

Leaders engaged with external partners to build a shared understanding of challenges and opportunities for the service. They attended a range of external conferences and sat on pan London network groups. It was clear that divisional leaders were invested in ensuring the new clinical services strategy took a systems wide approach to the planning of services. It was explained that a previous proposed service model for the hospital had not worked out, so wider staff consultation on the new children’s strategy going forward had not yet taken place.

The service invited patient and public involvement through various engagement activities, satisfaction surveys and patient groups. They took informal feedback from patients and improved small aspects of the service. There was a patient experience strategy that described how the trust wished to empower all staff to put the patient experience at the heart of everything they did. The long
term aim of the strategy was to ensure that patients had a central role in all aspects of care provision, service design and improvement and assurance processes.

The trust took part in the annual NHS staff survey. In 2018, the division’s results showed that immediate line management was a concern. As a result, the trust ran several leadership summits with all line managers invited. At these two-hour summits, key themes from the survey were discussed, along with the respect for people framework and divisional culture in general. There was also a focus on improving the quality of appraisals and discussion of career progression and development.

Staff received daily updates at safety huddles. Managers took the time to recognise and thank staff for their work. Staff were invited to attend monthly ‘meet the chief’ sessions with the senior leadership team.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. Some staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation, although the workforce at the time of the inspection limited the amount of improvement initiatives that could take place.

All staff we spoke with could tell us about improvements that had taken place in children’s services since our last inspection, as well as learning from serious incidents across the division which had led to changes in practice. An example of this was the appointment of three clinical nurse specialists (CNSs) for asthma between June and October 2019, in response to serious incidents relating to children who died of asthma attacks within the borough in recent years. One CNS would eventually work across primary and secondary care in each borough within the trust, running nurse-led clinics and providing comprehensive education and support to children affected by asthma. It was anticipated that this would reduce acute hospital attendances, length of stay and treatments relating to children with asthma.

The trust was committed to using quality improvement (QI) methodology to improve patient experience and quality of care provided. Some staff had received training in QI methodology and had been encouraged to contribute to workshops to identify how processes could be improved. Some of the staff we spoke to told us there was a big emphasis on learning and improvement within the trust, with the fact the trust had been restricted financially meaning they were “working smarter, not harder”. Other staff noted that there had not been time to participate in improvement projects or conduct research due to the historic issues with both nursing and medical staffing, although they were hopeful that this would improve with the recent recruitment.
## Facts and data about this service

Barking, Havering and Redbridge University NHS Trust provides outpatient services for routine, diagnostic and cancer pathways from two main sites, Queens Hospital in Romford and King George Hospital in Ilford. Other services are provided in the communities of Barking and Dagenham, Havering, Redbridge and Brentwood.

Between March 2018 and February 2019, there were 293,352 first and follow-up outpatient appointments held at King George Hospital.

The hospital provides a range of services and clinics for outpatients, including: general surgery, ear, nose and throat (ENT), breast surgery, cardiology, gynaecology, respiratory medicine, neurology, orthopaedics, trauma, urology, ophthalmology, endocrinology, rheumatology, gastroenterology, general medicine, pain management and dermatology.

The trust’s appointments centre was based at King George Hospital and was responsible for booking first outpatients appointments for consultant-led clinics.

### Total number of first and follow up appointments compared to England

The trust had 789,541 first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen's Hospital</td>
<td>690,254</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>293,352</td>
</tr>
<tr>
<td>Fanshawe Clinic (Outreach)</td>
<td>44,733</td>
</tr>
<tr>
<td>Brentwood Community Hospital - Outpatients</td>
<td>25,053</td>
</tr>
<tr>
<td>Loxford Polyclinic</td>
<td>11,238</td>
</tr>
<tr>
<td>This Trust</td>
<td>1,150,308</td>
</tr>
<tr>
<td>England</td>
<td>109,330,519</td>
</tr>
</tbody>
</table>

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Barking, Havering and Redbridge University Hospitals NHS Trust from March 2018 to February 2019 by site and type of appointment.
(Source: Hospital Episode Statistics)
Mandatory Training

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

Staff received, and kept up-to-date with, their mandatory training. All staff were required to complete relevant mandatory training modules as part of their induction and to complete refresher training, as required, in line with the trust's training policy. Training was delivered through a combination of online assessment and practical training days.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff completed online training modules on the trust's e-learning system. Staff told us they were given time to complete this training.

The trust set a target of 90% for completion of all mandatory training courses with the exception of information governance which had a target of 95%.

A breakdown of compliance for mandatory training courses from April 2019 to June 2019 for qualified nursing staff in the outpatients department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict resolution initial training</td>
<td>11</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>11</td>
</tr>
<tr>
<td>Infection prevention and control level 2</td>
<td>11</td>
</tr>
<tr>
<td>Fire safety</td>
<td>11</td>
</tr>
<tr>
<td>Sepsis (adult) e-learning</td>
<td>11</td>
</tr>
<tr>
<td>Health, safety and welfare</td>
<td>11</td>
</tr>
<tr>
<td>Resuscitation level 2 - adult basic life support</td>
<td>10</td>
</tr>
<tr>
<td>Equality, diversity and human rights</td>
<td>10</td>
</tr>
<tr>
<td>Infection prevention and control - aseptic non-touch technique (ANTT)</td>
<td>10</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
</tr>
</tbody>
</table>

At King George Hospital outpatients department, the target was met for nine of the ten mandatory training modules for which qualified nursing staff were eligible.

The trust was not able to provide mandatory training data for specifically for medical staff working within outpatients services.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
Staff received training specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2019 to June 2019 for qualified nursing staff in the outpatients department at King George Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2019 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>11</td>
</tr>
<tr>
<td>Safeguarding adults level 3</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>8</td>
</tr>
</tbody>
</table>

Staff knew how to identify adults and children at risk of, or suffering, significant harm and could give examples of how to protect patients from harassment and discrimination.

The service had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. The hospital’s safeguarding policies were within their review date and included information on female genital mutilation (FGM). Staff had access to information on how to recognise, respond and refer safeguarding concerns. We saw information on how to recognise and respond to safeguarding concerns was visibly displayed within the department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a named safeguarding lead for outpatient services and a trust safeguarding nurse who staff could access for advice and support. In addition, there was a registered children’s nurse in the children’s outpatient’s department whom staff could contact for any concerns identified with children.

The trust was not able to provide safeguarding training data for specifically for medical staff working within outpatients services.

Cleanliness, infection control and hygiene

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

The department was visibly clean and had suitable furnishings which were clean and well-maintained. Staff followed infection prevention and control (IPC) policies and procedures including the use of personal protective equipment (PPE).

Staff had access to appropriate handwashing facilities. Staff had access to sinks in clinical areas including consultation and treatment rooms. Staff, patients and visitors were reminded to use sanitising hand gel at the entrance to the department and when entering clinical areas.

Staff cleaned equipment after patient contact and used green ‘I am clean’ labels to indicate that it had been cleaned and was ready for use. There were appropriate processes in place to decontaminate reusable instruments and equipment.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff followed appropriate IPC procedures, including using specially designated colour coded equipment to clean different areas. Staff followed a daily cleaning rota and maintained a record of which areas had been cleaned.
The department participated in both local and trust-wide audits each month to assess compliance with IPC requirements. Staff carried out monthly audits to assess hand hygiene compliance, use of PPE and decontamination of equipment. Audit results for the six months prior to our inspection showed good compliance with standards.

Environment and equipment

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

The design of the environment was appropriate for the services being provided. The service had suitable facilities to meet the needs of patients and their families. The main outpatient department was based on the ground floor of the hospital close to the main entrance to the building.

The service had enough suitable equipment to help them to safely care for patients. We saw that most equipment displayed a sticker with its most recent testing date and that all the items were checked were within date for testing.

The service also had items of specialist equipment, for example, naso-endoscopes, which were maintained through separate arrangements. Whilst most individual service contracts were up to date, three items of equipment we checked did not have evidence of any servicing or maintenance checks. We raised this with matron who immediately escalated this to the trust’s estate team who removed the equipment and arranged for maintenance and safety checks to be carried out.

Emergency equipment was readily available. Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment daily against a checklist to ensure essential equipment was available and in working order.

Staff disposed of clinical waste safely. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed appropriate waste segregation procedures. Sharps bins were available and disposed of appropriately.

Disposable equipment and clinic room supplies, such as dressings and syringes, were stored appropriately, and all items we inspected were within their expiry date.

Assessing and responding to patient risk

Staff had the right skills and knowledge to identify and quickly respond to patients who became unwell within the department. However, the trust lacked effective systems and processes to assess and monitor the risk of harm to patients because of delayed access to appointments or long waits for treatment.

Staff attended daily safety huddles to share key information to keep patients safe. Staff were made aware when children or patients with additional support needs, such as a mental health condition or learning disability, were due to attend. Staff were able to access additional support for example, from the learning disabilities, dementia and specialist mental health teams, if needed.

Staff were able to contact a registered children’s nurse for support at any time. Although the main outpatient service saw only a very small number of children within adult’s clinics, they had a separate dedicated waiting area which was next door to the matron’s office.

Staff responded promptly to any sudden deterioration in a patient’s health. Staff had clear guidance and training on what to do if a patient became unwell within the outpatients department. Patients
who were critically unwell, for example those requiring cardiac monitoring, were transferred to the emergency department (ED). The nurse in charge of outpatients was responsible for assessing the patient, making any decision to transfer to ED and providing a handover to the nurse in charge of ED. Patients who were well enough to be cared for within the outpatients department could be transferred directly to an appropriate inpatient ward if required. The doctor making the decision to admit would contact the hospital’s site manager to book a bed. The patient was monitored by a nurse until a bed became available.

The hospital used the national early warning score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate, which are then used to calculate a score indicating the severity of a patient’s acute illness. This system helped staff to identify patients who were deteriorating and provide them with increased support. Nursing staff we spoke with understood how to escalate patients appropriately and told us that they felt supported by medical colleagues.

Staff used the World Health Organisation (WHO) surgical safety checklist for patients undergoing minor surgical procedures within the outpatients department. Staff followed a safety checklist to confirm the patient’s identity and minimise avoidable risks during the procedure. During the inspection, we asked if there were any local safety standards for invasive procedures (LocSSIPs) in place to build on the existing WHO surgical checklist. We saw a minor surgical procedures protocol which provided guidance for staff on how to ensure patient safety before, after and during the procedure. Following the inspection, the service introduced a standard operating procedure (SOP) for identification of patients attending outpatient appointments. The purpose of the SOP was to prevent communication errors resulting in incorrect treatment being provided to the patient. The SOP provided guidance for staff on how to identify patients by asking for name, date of birth and address.

Senior staff told us that the trust had a process to identify the risk of deterioration or harm to patients, as a result of a long wait for treatment. We were told that each week the list of patients who had been waiting for more than 38 weeks was sent to speciality services for review. Where there was a delay in reviewing the patient, or where potential risk of deterioration or harm was identified, we were told these patients would be escalated for review at the recently established twice-weekly ‘huddles’ led by the chief operating officer (COO). The purpose of these huddles was to identify and remove constraints that affected bookings or admissions and caused delays to patient care.

However, we found this process was not well embedded and lacked consistency and therefore did provide effective oversight of patient risk. This was because there was no standardised process across speciality departments to ensure patients were regularly reviewed for risk of harm or deterioration as a result of waiting for treatment. The trust recognised this as an area for improvement and had begun work to standardise this process. However, as this was not yet in place, it was not clear whether patients had come to harm through delays or long waits.

In addition, we were told this process was only for patients waiting for a first appointment, and there was no central governance or oversight of those patients waiting for follow-up appointments. We saw evidence that the trust had identified this as a concern in February 2019 and a serious incident (SI) had been reported. The initial SI indicated that 171,000 referrals, which were waiting for a follow-up appointment, were not being actively monitored. However, as we were told the outcome of the investigation was still not yet available, the full scale and impact of the issue was not clear. Although this issue had recently been added as a risk on the trust’s corporate risk register, at the time of the inspection we saw no evidence of action taken to mitigate the risk. In addition, due to a backlog of clinical harm reviews the trust was unable to provide assurance that patients had not come to harm.
Since April 2018, the trust had carried out clinical harm reviews for all patients who waited longer than 52 weeks and on a random sample of 10% of patients waiting between 30 and 52 weeks.

The trust provided data to show that as at 30 September 2019, there were 205 clinical harm reviews which were outstanding, this represented 35% of the total patients selected for a clinical harm review for the period January to August 2019. Of these 205, there were 43 patients who had waited over 52 weeks for treatment. As clinical harm reviews had not been completed, it was unclear whether these patients had come to harm as a result of the long wait and delay in treatment. The specialities with the largest number of outstanding harm reviews included pain management (71), trauma and orthopaedics (36) and gynaecology (21) and ophthalmology (12). In addition, it was reported that there were two paediatric patients with a wait of between 30 and 52 weeks, which had not yet been reviewed for risk of harm.

We were told that patients waiting longer than 52 weeks were reviewed on a weekly basis and there was a clear escalation process in place if patients needed to be seen at short-notice. The deputy COO chaired a weekly ‘access board’ to review referral to treatment time (RTT) performance against the national standard. The service was responsive to requests to add additional clinics at short-notice to see patients sooner if necessary. However, the same scrutiny was not applied to ‘non-RTT’ patients, those who were waiting for a follow-up appointment.

The trust’s risk assessment process only applied to patients waiting for a first appointment and we found that waiting times and the risk of clinical harm to patients waiting for a follow-up appointment was not consistently monitored or reviewed. Data provided by the trust for October 2019 showed that there were 832 patients waiting more than 18 weeks for an ‘urgent’ follow-up appointment, including three patients waiting over 52 weeks. Additionally, there were 2,572 patients waiting more than 18 weeks for a ‘routine’ follow-up appointment, six of which had been waiting over 52 weeks. The trust did not provide any assurance of how the risk of harm to these patients was being monitored, reviewed or addressed.

As responsibility for monitoring of the ‘non-RTT’ patient waiting list sat with individual specialities, there was a lack of central oversight of follow-up pathway delays. This lack of governance and oversight meant it was unclear how the trust gained assurance that patients waiting for a follow-up appointment had not come to harm.

The trust had identified several serious incidents in the 12 months prior to our inspection which impacted on patient waiting times. At the time of our inspection, not all clinical harm reviews had been completed, therefore the trust was unable to provide assurance that patients had not come to harm. Data provided for September 2019 showed that of the 1,823 patients selected for harm reviews, only 162 harm reviews (9%) had been completed.

Nurse staffing

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

During the inspection, there were sufficient staff in the department to keep patients safe.

Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with local staffing guidance. Although there are no national
standards or guidelines on how outpatients clinics should be staffed, the service had developed its own local staffing matrix to identify and review safe staffing levels.

Senior staff reviewed staffing levels on a daily basis and calculated shift fill rates to determine whether action was needed. Staffing short-falls of 10% or over required escalation to the matron for review and above 15% required staff to report this a safety incident. Staff told us that where gaps in the rota were identified, due to sickness or short notice absence, for example, cover was arranged either using staff from other clinic areas within the trust or bank staff. Most staff worked between 8am and 6pm, with at least one registered nurse working a late shift each day to provide cover for evening clinics.

Managers made sure that all staff, including bank and agency staff, had a full induction and understood the service. There were arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

The table below shows a summary of the nursing staffing metrics in outpatients at King George Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>9%</td>
<td>13%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>74.2</td>
<td>10.7%</td>
<td>10.0%</td>
<td>22.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>11.9</td>
<td>4.2%</td>
<td>9.4%</td>
<td>20.7%</td>
<td>1,823.3 (7.4%)</td>
<td>0.0</td>
<td>027 (&lt;1%)</td>
</tr>
</tbody>
</table>

Medical staffing

Doctors who worked within outpatients services were associated with various surgical and medical speciality services rather than the outpatient department, so this data was not collected or monitored by the outpatient department. The trust told us it was not possible to specifically identify the medical workforce solely within outpatient services as medical staff rotate and clinics and services were provided across multiple divisions.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, easily available to all staff providing care. However, records were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Since our last inspection the trust had introduced an electronic referral process, which meant that the most first referrals were received electronically from the patients GP using the national NHS Electronic Referral Service (eRS). Whilst the majority of patient records were paper-based, the trust
was in the process of introducing more digital processes as part of its transformation programme. Consultants in some specialities, were now able to report clinic outcomes electronically. Staff told us that patient’s notes were almost always available in time for their appointment. Records were electronically tagged which made them easier to locate. Staff told us if notes were not available this was raised as an incident and investigated. Staff were able to create a set of ‘temporary’ notes using any patient information available from the trust’s electronic record systems. Consultants would decide whether patients could be seen with temporary notes. Temporary notes were placed within a distinctive blue folder alerting the clinician to the fact that some information may be missing and were merged as soon as possible with the original record. Data provided by the trust, for the 12 months prior to the inspection, showed that only 11 appointments had been cancelled due to notes being unavailable. We reviewed five sets of patient records and found that notes were generally completed to a high-standard and detailed the plan for the patient going forward. However, whilst all notes were signed and dated, there was no record of the job role of the member of staff or the time the notes were completed.

We saw that patient records were not always stored securely. Staff from medical records delivered patient records to a locked room within the department. Nursing staff then collected these and stored them in lockable notes trolleys outside of clinic rooms. The matron told us the trolleys were lockable but the locks were not used as staff were always in the area. However, we saw that one unlocked trolley containing notes was left under the electronic patient information board in the base two waiting area, which was not always supervised by staff.

The trust’s policy on health records management stated that, “health records must be stored in an area where patients, members of the public and unauthorised staff are unable to gain access to them. Where records are stored in areas that do not have a 24/7 staff presence then they must be secured in an area that is securely locked when the premises are unstaffed. Patient records must not, under any circumstances, be left unattended unless properly secured.” This meant staff were not always following the trust policy and that patients’ records could potentially be viewed by unauthorised people.

**Medicines**

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the outpatients department.

Staff followed guidance on how to monitor medication fridge temperatures. We saw that staff had taken appropriate action when temperatures were recorded outside of the required range.

Staff stored prescription pads and records securely in a locked cabinet. Staff followed the hospital’s policy for issuing prescriptions to patients. Senior staff carried out weekly audits to confirm staff were following the correct process for storing and prescribing medicines.

Staff followed current national practice to check patients had the correct medicines and provided specific advice to patients and carers about their medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
Incidents

Staff knew what incidents to report and how to report them. However, learning from serious incidents (SIs) was not shared with staff. The trust had reported multiple SIs in the 12 months prior to our inspection which impacted on many patients waiting for outpatients appointments. However, most staff were unaware of these incidents. This meant opportunities to improve safety processes and prevent future incidents were missed. In addition, the delays in investigating SIs and failure to implement actions to address the root causes, had led to similar SIs reoccurring.

Staff knew what incidents to report and how to report them. There were effective processes to record and manage incidents. Incidents were reported using the trust’s electronic recording system. Staff we spoke with knew how to report incidents and were aware of the types of incidents they needed to escalate.

There were no reported never events within this service. Never events are a type of serious incident that is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The trust had identified six serious incidents (SIs) in the 12 months prior to our inspection which had impacted on patient waiting times. Several incidents involved serious IT issues, one of which had resulted in a large number of letters and documents (43,000) not being sent out and another led to letters for 2,358 patients going to the incorrect address.

The trust had investigated three of the six SIs and identified root causes and action plans to address areas for improvement. SI investigation reports from February and March 2019 identified there were delays in investigation and sharing the learning from SIs. These included failures within the trust’s IT systems, ineffective or absent systems and processes to monitor patient pathways and failure to implement learning from previous SIs. Most staff we spoke with were not aware of these SIs and we did not see any evidence that learning had been shared. This meant opportunities to improve processes and prevent future similar incidents from occurring were missed.

The trust had recently added risks related to these SIs to their corporate risk register. These included the risk of potential harm to patients by delaying their pathway and the risk that IT systems, and the use of these systems by staff, contain further issues that could result in further incidents. Whilst this indicated that the trust recognised the seriousness of these incidents and the potential they could re-occur, we saw little evidence of action taken to mitigate these risks, and therefore it was still possible similar SIs could occur. The trust’s failure to implement learning from previous SIs had been identified as a contributory factor in at least one case. In addition, re-occurring themes raising concerns about data accuracy and validation processes, demonstrated other SIs were likely to have common root causes.

Staff within the outpatient service at King George Hospital reported 109 patient safety incidents between October 2018 and September 2019. The majority of these (85) were no harm, low harm (11) or a near miss (11). There were two incidents of moderate harm. The main reasons for staff reporting incidents were delays, waiting times and cancellations.

Staff told us they received feedback on local incidents through daily ‘safety huddles’ where they met as a team to discuss the feedback and look at improvements to patient care. However, most staff were unable to give us any examples of changes in practice as a result of learning from incidents. Senior staff told us that lessons learned from incidents were shared with staff via safety bulletins and
discussed at team meetings. However, bulletins and meeting minutes we reviewed did not demonstrate this and most staff we spoke with were unaware of the SIs which had taken place.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This means providers must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

We asked the trust to provide examples of any recent compliance with duty of candour, this was required for one of the serious incidents. The investigation report made reference to considerations around duty of candour. The trust explained that, given the number of patients involved in the incident further investigations were ongoing to determine whether the duty of candour applied for each individual patient and the specifics of the harm arising.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed treatment guidelines based on National Institute for Health and Care Excellence NICE. Staff were able to access trust policies and procedures on the trust intranet. Policies we reviewed, including those for safeguarding and information governance, were within their review date. Staff had access to guidance documents for local processes and procedures, where relevant, for example on the escalation of a deteriorating patient within outpatients.

The trust held a monthly clinical outcomes and effectiveness group meeting, chaired by the associate medical director. Senior clinical and nursing staff met to review the results of clinical audits, updates to guidelines and patient outcomes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients had access to water in waiting areas. Staff gave patients a pager if they wanted to leave the waiting area to go to the hospital canteen or shop to buy something to eat.

Nursing staff were able to contact dieticians and speech and language therapists if patients required further assessment or support with eating or drinking.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, patients could not always access pain management services when they needed them.
Staff were able access appropriate pain relief for patients within outpatient department clinics. Most patients told us their pain was well-managed. If patients were in pain, staff were able to provide pain relief or make a referral to the pain team if required.

The trust held an outpatients pain management clinic. The trust told us they were experiencing continued capacity issues which meant many patients were waiting a long time to access pain management services. This meant that many patients could not always access pain management services when they needed them. We spoke with one patient who told us they had waited over 18 months for an appointment with the pain management team.

Data provided by the trust for September 2019 showed that there were seven patients waiting more than 52 weeks for an appointment with the pain management team. For four of these seven patients, their delay was recorded as being ‘avoidable’, due to technical issues with the trust’s waiting list management systems. In addition, due to a delay in carrying out clinical harm reviews the trust was unable to provide assurance that patients were being appropriately risk-assessed and no patients had come to harm as a result of waiting for treatment.

**Patient outcomes**

Staff monitored how effectively outpatients clinics were organised and used the findings to make improvements to improve services for patients. However, the service did not effectively monitor outcomes for all patients to ensure they received effective care and treatment.

The outpatients’ service did not generally participate in local or national clinical audits. These were undertaken by medical and surgical specialities. The trust had an annual audit programme and was contributing to over 60 audits across a range of medical and surgical specialities, including the national ophthalmology audit, the national diabetes audit and UK Parkinson’s audit.

Since our last inspection, the service had introduced audits to record how effectively clinics were running. Nursing staff gathered data on whether clinics were running to time, when the first and last patient were seen, and if there were any reasons for delays. The service’s patient experience lead was responsible for collating this data, highlighting any trends or issues of concern and escalating these to the matron. The matron then used this information to have discussions with speciality leads. The patient experience lead told us this audit data had helped to enable effective conversations with service managers, patient pathway managers and speciality leads and had led to improvements within the service. For example, by identifying that certain clinics were always overrunning and that this was due to the number of patients being seen with additional and complex support needs, the data provided justification for longer appointment slots.

Nursing staff carried out monthly audits to assess compliance with infection control requirements. Staff carried out monthly audits to assess hand hygiene compliance and decontamination of equipment. Audit results for the six months prior to our inspection showed good compliance with standards.

The trust was working with local commissioners to identify further opportunities to outsource some speciality services to increase capacity and reduce patient waiting lists. For example, there were plans to start outsourcing of benign hysteroscopy to create additional two week-wait capacity, enabling patients with suspected cancer to be seen more quickly. The trust was also in discussions with commissioners about outsourcing pain services but as this had been delayed the service was considering other plans to reducing their waiting list, including introducing virtual clinics and enhancing triaging processes to reduce inappropriate referrals.
Whilst the proportion of new and follow-up patients seen at the hospital was similar to the England average, the trust did not have effective processes in place to consider the needs of all patients waiting for appointments at the hospital. The trust prioritised new patients and those patients on a referral to treatment (RTT) pathway. There was no central governance or oversight of those patients waiting for follow-up appointments.

Senior staff told us that the trust had a process to identify the risk of deterioration or harm to patients, as a result of a long wait for treatment. However, we found this process was not well embedded and lacked consistency and therefore did provide effective oversight of patient outcomes. There was no standardised process across speciality departments to ensure patients were regularly reviewed for risk of harm or deterioration as a result of waiting for treatment.

The trust's clinical outcomes report for September 2019 showed that the pain management speciality had a back-log of outstanding harm reviews. The service reported that a total of 71 patients who had waited 30 weeks or longer, between January and August 2019, had not yet been reviewed to see if their condition had deteriorated as result of waiting for treatment. At the time of our inspection, the pain management service reported 2,008 patients were waiting for treatment, of which over half (1,141) had been waiting over 18 weeks for an appointment, including 66 patients who were waiting for an 'urgent' appointment. It was not clear how the service was monitoring outcomes for these patients and ensuring they received effective care and treatment.

## Competent staff

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

There were arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers supported staff to identify training needs and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Staff had received specific training to understand the additional needs of people with mental health conditions, a learning disability, autism or dementia.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers told us they were well supported by the matron and the patient experience lead.

From April 2018 to March 2019, 85.1% of staff working within the outpatients department at the hospital received an appraisal compared to a trust target of 90%. Although this did not meet the trust target, it was better than the trust average of 76.5%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>12</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>20</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>8</td>
</tr>
<tr>
<td>All staff groups</td>
<td>40</td>
</tr>
</tbody>
</table>
The trust was not able to provide appraisal data for specifically for medical staff working within outpatients services.

**Multidisciplinary working**

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

We saw that care was delivered in a coordinated way and that staff in different teams were involved in providing person-centred care. There was evidence of staff working together to meet patient’s needs. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic testing.

There were clinical nurse specialists available in clinics such as the diabetes, respiratory and dermatology clinics. These staff worked closely with consultants and specialist support services to improve care and treatment for patients with specific conditions.

The service worked closely with the local commissioners to identify opportunities to improve service capacity, for example by supporting GPs to make appropriate referrals.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Outpatient clinics were held at various times from 8am to 6pm, Monday to Friday. Clinics in the main outpatient department did not routinely provide a seven day a week service. However, some waiting list initiative clinics were held in the evenings and at weekends to reduce the number of patients waiting for an appointment. During July 2019, the outpatient department put on an additional 287 clinics, providing appointments to 3,523 patients, of these 40 clinics were held at weekend and 39 in the evening.

**Health Promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The department provided information in each clinic area to inform patients and carers of support groups available in the local and wider area. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients, including bereavement charities which offered both psychological and financial support.

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent for outpatient appointments that did not require an invasive procedure was implied consent. This meant that it did not necessarily need to be documented in the patients notes. For example, when taking a patient’s blood pressure, the nurse would ask the patient to hold out their arm so they could attach the strap, if the patient complied with this request then consent was
implied. Where patients were undergoing invasive procedures, such as biopsies, injections and minor surgical procedures, written consent was required. Patients told us they had been asked for written consent before procedures took place. Staff recorded consent in the patients’ records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at King George Hospital for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 of March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>11</td>
</tr>
</tbody>
</table>

In outpatients the target for MCA/DOLS training was met by qualified nursing staff at this site.

The trust reported no medical or qualified allied health professional staff within this core service.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

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

Patients said staff treated them well and with kindness. Patients, their relatives and carers, were overwhelmingly positive about the care they received from staff in the outpatients service. We spoke with 25 patients and relatives during the inspection and all spoke positively about how they had been treated by staff.

Staff were discreet and responsive when caring for patients, taking care to respect their privacy and dignity, for example by ensuring doors and curtains were closed before any examination or treatment took place. Staff took care to knock on clinic doors and wait for a response before entering, to ensure patients were ready for them to enter. Nursing staff were trained as chaperones to support patients during intimate examinations.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients were able to bring a relative, carer or friend into their appointments with them if they needed support.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff had
received specific training to understand the additional needs of people with mental health conditions, a learning disability, autism or dementia.

Patients gave positive feedback about the service. Of those patients who provided feedback to the trust in August 2019, 95% said they would recommend the service to family and friends.

The Friends and Family Test (FFT) was used across the trust to gather feedback from patients so they could give comments on their experiences and state whether they would recommend the service. The trust had received 14,453 response between September 2018 and August 2019 from patients attending outpatient services. Although the trust told us they did not monitor response rates, this equated to roughly 5% of the 293,352 patients seen within outpatients at King George hospital between March 2018 to February 2019. Data provided by the trust below, showed that the hospital performed better than the London average.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Average outpatient % positive</td>
<td>90.00%</td>
<td>92.00%</td>
<td>92.00%</td>
<td>91.77%</td>
<td>92.22%</td>
<td>92.05%</td>
<td>92.03%</td>
<td>91.83%</td>
<td>91.36%</td>
<td>91.73%</td>
<td>52.03%</td>
<td>Not available yet</td>
</tr>
<tr>
<td>recommendation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHRUT % positive recommendation</td>
<td>93.84%</td>
<td>95.01%</td>
<td>94.06%</td>
<td>94.50%</td>
<td>95.38%</td>
<td>94.26%</td>
<td>93.13%</td>
<td>94.40%</td>
<td>96.00%</td>
<td>94.94%</td>
<td>94.57%</td>
<td>94.94%</td>
</tr>
<tr>
<td>Number of responses received</td>
<td>1055</td>
<td>1162</td>
<td>1296</td>
<td>855</td>
<td>1190</td>
<td>993</td>
<td>830</td>
<td>1808</td>
<td>1149</td>
<td>1087</td>
<td>1548</td>
<td>1880</td>
</tr>
</tbody>
</table>

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff and volunteers supported patients and their relatives or carers. The service had a dedicated volunteer ‘patient partner’ and patient experience lead, who could provide support to patients who were anxious or nervous about their appointments.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were aware that some patients living with additional support needs, such as dementia or autism, may find the experience of visiting hospital disorientating or upsetting. There were quiet areas where patients could wait if they found the busy environment distressing. The service worked closely with local services for people with autism and learning difficulties to provide orientation visits to help patients become familiar with what to expect when they visited the outpatient services at the hospital. Designated staff were trained as dementia champions and supported their colleagues providing care to patients living with dementia.

**Understanding and involvement of patients and those close to them**

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids or interpreters where necessary.
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The outpatients department took part in the ‘iWantGreatCare’ patient experience survey. Patients could post their responses into boxes in the waiting areas. Posters and leaflets encouraged patients to provide feedback by leaving comments or suggestions using the forms provided. Staff could give examples of how they used patient feedback to improve daily practice, for example by introducing a mobile text reminder service to reduce the number of missed appointments.

The outpatient service had a dedicated ‘patient partner’ who was also a trust volunteer. Their role was to act as the voice of the patient and represent patient views at a range of trust meetings and forums. The department’s patient partner told us that they were well-supported and felt actively engaged in plans to improve services.

Is the service responsive?

Service delivery to meet the needs of local people

The service did not consistently plan and provide care in a way that met the needs of local people and the communities it served. However, the trust was working with others in the wider healthcare system to improve how it planned and provided outpatient services.

The trust recognised it needed to take action to improve outpatient services to meet the needs of the local community. The trust told us they did not have the required capacity to meet current demands on outpatient services. At the time of this inspection, there were a total of 34,707 patients waiting for outpatient appointments, of which 8,068 had been waiting for over 18 weeks; including 1,146 patients who had been referred as ‘urgent’. Ten patients had been waiting for over 52 weeks for treatment.

The trust received over 350,000 referrals to outpatient services each year. These were primarily from GPs, with a smaller number from consultants and from the emergency department (ED). In August 2019 alone, the trust received approximately 15,000 GP referrals, 9,000 consultant referrals and 3,000 referrals via the ED. The trust saw approximately 2,000 patients in outpatients every day, across all locations where services were provided within the trust.

The leadership team described the outpatient service as being on an ‘improvement journey’. The service worked closely with commissioners, GPs and patient partners to develop and improve processes to meet the growing needs of the patient population. The service had held a series of workshops to engage staff and stakeholders in quality improvement processes and to encourage innovative thinking around how services could be improved.

The service had a ‘transformation’ plan to increase the capacity, reduce waiting times and the demand on the service. The service’s plans included introducing virtual clinics and enhancing triaging processes to reduce inappropriate referrals. These processes were being piloted within some specialities and had already proven successful, however, additional funding and resources were required to expand these initiatives into other areas.

The trust worked with local commissioners to identify further opportunities to outsource some speciality services to increase capacity and reduce patient waiting lists. For example, there were plans to start outsourcing of benign hysteroscopy to create additional two week-wait capacity, enabling patients with suspected cancer to be seen more quickly.

The main outpatient department was based on the ground floor of the hospital close to the main entrance of the building. The layout of the department had recently been redesigned around four
main waiting areas. The main reception desk had moved further from the entrance to the department
and closer to the main waiting area. Staff told us that patients sometimes got confused by the layout
of the department and there were plans to re-design signage to make it clearer where people
needed to go. Volunteers helped to sign-post patient to the reception desk and waiting areas.

The service also planned to introduce self-check-in services in early 2020 which would help improve
patient flow as there would be fewer patients queuing to speak to reception staff. Since our last
inspection, audiology and ENT services had re-located to ‘Base One’ which was previously occupied
by a GP service. Senior staff told us ENT services that had previously been held at one of the
hospital’s community clinic locations had now moved back into the main outpatient department at
King George Hospital. Staff said this had improved patient experience and reduced the number of
missed appointments.

The outpatient environment was appropriately designed to meet the needs of patients. There was
sufficient seating for patients, and those accompanying them, within waiting areas. People had
access to water, magazines, information leaflets and toilets. There was a separate waiting area for
children with access to toys and a television. Patients could take a pager, which would notify them
when they were being called, and go to the shop, canteen or atrium area, which reduced the
demand on the waiting area and allowed patients greater freedom.

The service had systems to help care for patients in need of additional support or specialist
intervention. Services provided by the outpatient department included consultant-led clinics, nurse-
led clinics and rapid access and ‘one-stop’ services. For example, patients were able to attend one-
stop breast clinic services for assessment, screening and a range of diagnostic tests.

Outpatient clinics were held at various times from 8am to 6pm, Monday to Friday. Clinics in the main
outpatient department did not routinely provide a seven day a week service. However, some
additional ‘ad-hoc’ clinics were held in the evenings and at weekends to reduce the patient waiting
list. Staff told us that there were approximately 200 additional clinics added every month to address
waiting list back-logs. During July 2019, the outpatient department put on an additional 287 clinics,
providing appointments to 3,523 patients, of these 40 clinics were held at weekend and 39 in the
evening.

Managers monitored and took action to minimise missed appointments. Staff contacted patients who
did not attend appointments. Patients attending outpatient appointments were sent a text message
seven days in advance of their appointment, as well as a 48-hour reminder text. Patients were able
to cancel and rebook their appointments by responding to the first text message. Patients told us
they had received these messages and that communication with the hospital had generally been
good.

Between July 2018 and June 2019, the did not attend (DNA) rate for patients at King George
Hospital was approximately 10%, which was higher than the England average at approximately 7%
for the same period.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Barking, Havering and Redbridge
University Hospitals NHS Trust**
More recent data provided by the trust, for the 12-month period prior to our inspection, showed patient DNA rates at King George Hospital continued to be higher than the England average. Data showed that overall 10.9% of patients did not attend their appointment. DNA rates were also higher than at Queens Hospital, and other outpatient services within the trust. The hospital’s performance had not shown improvement since our last inspection. Specialities with the highest DNA rates included diabetic medicine (20.5%), stroke (18.9%), hepatology (16.8%) and colposcopy (16.4%). Specialities with the largest numbers of patients not attending included physiotherapy (15,418), ophthalmology (9,622) and trauma (7,534).

On one day of our inspection, the trust told us that 33 patients had not attended their appointments, including three patients referred under a two-week cancer wait pathway. The trust had attempted to contact the patients by telephone, however as appointment letters had only been sent out 48hrs before the appointment, these had not been received by the patients in time. We were told these three cases were not recorded as a ‘DNA’ on the system as the patient had “not been appropriately notified of their appointment”. It was not clear why these patients would not be included within the trust’s DNA performance data. Following our inspection, the trust explained that recording patients who did not attend when they had not received the appropriate communication was against their policy, as doing so had the potential to trigger a review of the patients’ attendance, which could result in their being referred back to their GP.

The trust’s chief nurse provided reassurance that all patients who missed their appointment were contacted and appointments provided to ensure they would be seen within the two-week target timeframe. We were told this would be raised as an incident and investigated. However, based on this information, it was not clear whether the trust was recording all DNAs appropriately and whether the reported performance data was accurate.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff told us they could access help from interpreters or signers when needed. There was a hearing loop installed for those patients with hearing aids. Whilst we did not see any information leaflets available in languages other than English, staff told us these could be requested if necessary. However, we were told that the patient feedback survey was only available in English.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff had supported from the trust dementia team and were assigned a dedicated health care assistant who attended the staff huddles and when required to support patients living with dementia.

The service worked closely with local charity groups to support patients with autism and learning disabilities. This included arranging for people to visit the department to become familiar with the environment and with staff. Staff told us this was also helpful in raising awareness of individual needs.

Staff attended daily safety huddles to share key information to keep patients safe. Staff were made aware when patients with additional support needs, such as a learning disability, were due to attend. The patient experience lead and volunteers were able to provide additional support to patients if needed. Staff were aware that some patients living with additional support needs, such as dementia or autism, may find the experience of visiting hospital disorientating or upsetting. There were quiet areas where patients could wait if they found the busy environment distressing.

Staff were able to tell us how they supported people with learning disabilities, dementia or other additional support needs. Staff said information could be provided in ‘easy read’ formats or large print. Staff discussed arrangements for patients with complex needs at morning ‘huddle’ meetings.

There were learning disability notice boards and notices in the outpatients department’s waiting area in easy read format explaining how people with a learning disability could access assistance in the department. The outpatients department used the hospital passport scheme for patients with learning disabilities. This was a document that patients could take to their appointments which carried information about the patients personal, communication, and health care needs.

The service provided access to out of hours clinics at evenings and weekends for some specialities, including speciality clinics for young people, so that they did not need to miss school or college.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards. Many patients had to wait a long time for an appointment.

Whilst managers monitored waiting times for new appointments, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets.

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. This is referred to as the referral to treatment (RTT) standard. Where patients are seen on an outpatient basis and do not require an admission to hospital as an inpatient, this is referred to as the ‘non-admitted’ pathway. Whilst there is no longer a national target for this performance measure,
NHS providers are required to monitor waiting times and report their performance to their commissioners. At the time of our last inspection, the trust was not reporting RTT publicly. This was due to concern about the accuracy and completeness of waiting list data. The trust also had a backlog of patients waiting over 52 weeks. The trust returned to reporting RTT performance data externally in December 2016.

From August 2018 to July 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways was slightly worse than the England overall performance. The latest figures for July 2019, showed 84.1% of this group of patients were treated within 18 weeks versus the England average of 86.1%.

Six specialties performed better than the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>94.9%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.0%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>89.4%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>87.7%</td>
<td>79.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>87.0%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>86.7%</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

Ten specialties were worse than the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>92.1%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Other</td>
<td>87.5%</td>
<td>89.4%</td>
</tr>
<tr>
<td>General surgery</td>
<td>87.0%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>86.7%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.5%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>83.7%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>81.9%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>67.1%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60.6%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>60.3%</td>
<td>76.8%</td>
</tr>
</tbody>
</table>
From August 2018 to July 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. The latest figures for July 2019, showed 78.9% of this group of patients were treated within 18 weeks against the England average of 85.3%.

Five specialties performed better than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral surgery</td>
<td>100.0%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>92.8%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>90.7%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>90.5%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>86.4%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>

Thirteen specialties were worse than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>94.7%</td>
<td>95.8%</td>
</tr>
<tr>
<td>General medicine</td>
<td>90.3%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>87.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>84.0%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Other</td>
<td>82.3%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>80.7%</td>
<td>81.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>80.3%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>79.9%</td>
<td>85.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>79.6%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>75.9%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>73.6%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>72.4%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0.0%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>
The trust performed worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral in the most recent two quarters. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing percentage of people seen by a specialist within 2 weeks of an urgent GP referral](image)

(Source: NHS England – Cancer Waits)

The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in each of the last four quarters. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing percentage of people waiting less than 31 days from diagnosis to first definitive treatment](image)

(Source: NHS England – Cancer Waits)

The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral in the most recent quarter. However, performance was better than the England average. The performance over time is shown in the graph below.

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment](image)
Although the trust had agreed an improvement plan with their commissioners with the aim of reducing the number of patients on their waiting list and improving RTT performance, this was not being achieved. Data provided by the trust below, shows poor performance against the planned trajectory. As at September 2019, rather than reducing as planned, the total waiting list size had grown to 5,679 patients above the trajectory. Similarly, the trust’s overall RTT performance had declined, at 74.7% against a trajectory of 83%. This meant that more patients were having to wait longer for an appointment at the hospital and fewer patients were being seen within the national standard of 18-weeks from referral.

Senior staff told us that challenges included clinic and theatre capacity, particularly for pain services, general surgery, trauma and orthopaedic, gynaecology and neurosurgery services. Senior staff told us the impact of the recent changes to NHS pension tax had reduced clinic capacity as the number of consultants prepared to work extra hours had reduced.

The trust recognised waiting time performance was poor and had developed a recovery plan to identify pressures and key actions to support improvement. The trust’s key priorities included strengthening governance arrangements, and operational processes, as well as improving data quality. The trust planned to introduce standardised processes to improve the consistency of waiting list monitoring within specialities with the aim of improving oversight of patients waiting for both first and follow-up appointments. To improve consistency, a new set of standards had been drafted which provided clear guidance for specialities on monitoring their patient tracking list (PTL). This included weekly meetings to review all patients without ‘next actions’ recorded and those who had breached their review date.
We asked the trust to provide details of their current governance arrangements for monitoring patients waiting for follow-up appointments and we were told, “there is no oversight at speciality level that reviews pathway delays and develops plans to overcome identified bottleneck to ensure all patients are treated within the constitutional standards, including those that are within the Non RTT PTL”.

The trust had arrangements to monitor patients waiting for a new appointment, through the twice weekly RTT ‘huddle’ and monthly access board meetings.

Data provided by the trust for October 2019 showed that there were 832 patients waiting more than 18 weeks for an ‘urgent’ follow-up appointment, including three patients waiting over 52 weeks. Additionally, there were 2,572 patients waiting more than 18 weeks for a ‘routine’ follow-up appointment, six of which had been waiting over 52 weeks.

Between September 2018 and September 2019 there were 78,018 cancelled outpatients appointments at King George Hospital. This equates to approximately 20% of all appointments for the period. Of these cancelled appointments, approximately half were cancelled by the patient, with the primary reason being due to the date being inconvenient. Of those appointments cancelled by the hospital, the main reasons recorded were clinical adjustment (9,375), clerical error (4,835) and no doctor available (4,004).

The service monitored and audited in clinic waiting times and used the data to make improvements to the service. Electronic screens in the main waiting areas informed patients of any clinic delays. In smaller waiting areas staff kept patients up to date if the clinic was running behind. Patients who wanted to leave the waiting area were given a pager to notify them when they were being called into clinic.

**Learning from complaints and concerns**

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

Managers investigated complaints, identified themes and shared feedback and learning with staff to help improve the services. The service recorded six formal complaints between October 2018 and September 2019. Themes included issues around waiting times, delays and communication. Staff knew about these issues and what the service was doing to address improve services in response.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain and the support available from the trust’s patient liaison and advice service was available in the form of posters and leaflets. Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to resolve complaints informally where possible. The service had a dedicated patient experience lead who was available to support staff and patients with complaints and concerns. The patient experience lead was available to provide assistance to patients where appointments had been changed or cancelled at short notice. Staff told us that this helped to reduce complaints as patients were able to resolve their concerns before they left the hospital.

The trust had taken action to address these areas by improving systems and processes. For example, all patients now received a text message seven days in advance of their appointment as
well as a 48-hour reminder text. This had resulted in a reduction in the number of concerns being raised around communication and missed appointments.

**Is the service well-led?**

**Leadership**

Leaders were visible and approachable in the service for patients and staff. They supported staff, and each other and worked as a strong, cohesive leadership team to deliver the vision and strategy of the service. However, whilst service leads had good knowledge of performance within their areas of responsibility, we were not assured they were fully aware of the risks and challenges impacting on the quality and safety of the service.

The service leadership team consisted of the head of patient administration supported by the outpatient matron and outpatient service manager. This team had responsibility for outpatient services across the trust. The head of patient administration reported directly to the trust’s deputy chief operating officer (COO) who had senior oversight for waiting time performance.

The service’s leadership team had good knowledge of the service within their individual areas of responsibility. However, we were not assured they fully aware of the risks and challenges impacting on the quality and safety of the service. For example, the leadership team did not have oversight of patients waiting for follow-up appointments (the ‘non-RTT’ patient waiting list). The senior team said responsibility for monitoring the ‘non-RTT’ patient waiting list sat with individual specialities, this meant there was a lack of central oversight of follow-up pathway delays. This lack of governance and oversight meant the trust was unable to gain assurance that patients waiting for a follow-up appointment had not come to harm.

The trust had reported multiple serious incidents (SIs) in the 12 months prior to our inspection which had impacted on patient waiting times. Several incidents involved serious IT issues and had resulted in delays to patients receiving care. However, not all senior staff were aware of these incidents. Service leads did not appear aware of the wider risks highlighted by these SIs or what the trust was doing to address these. The SIs raised concerns about data quality and revealed weaknesses and gaps in the effectiveness of systems and processes designed to validate the accuracy and completeness of patient waiting list data. It was not clear how the leadership team gained assurance that current systems and processes were effective in providing oversight of performance and risk.

Staff said they were well-supported and felt confident in raising concerns. They were positive about the leadership of the service and told us managers and senior leaders were approachable and visible within the hospital. Staff were encouraged to develop their skills and to take on more senior responsibilities.

The trust had arranged for NHS Elect to provide managers and staff with training on quality improvement and patient experience.

Leaders told us there were plans to introduce a clinical lead into the outpatients leadership team. Clinical input was provided on an informal basis by the divisional director for surgery, who was supporting the outpatient’s transformation programme and leading on the enhanced triage project.

**Vision and strategy**

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

The trust’s vision “to provide outstanding healthcare to our community, delivered with pride” was supported by five key values and behaviours. These had been developed by staff and were: passion, responsibility, innovation, drive and empowerment (known as PRIDE).

The trust’s mission statement, values and annual goals were clearly displayed around waiting areas within the outpatient department for staff, patients and visitors to see.

The outpatient department’s specific mission statement was to “make patients’ visit to the BHRUT outpatient department efficient, informative, and caring, within a safe and clean environment.” It was supported by a three-year transformation plan which set out how the service would be developed to improve efficiency and better meet patients’ needs.

The leadership team described the outpatient service as being on an ‘improvement journey’. The service was working closely with commissioners, GPs and patient partners to develop and improve processes to meet the growing needs of the patient population. The service had held a series of workshops to engage staff and stakeholders in quality improvement processes and to encourage innovative thinking around how services could be improved.

The service had an ambitious plan to significantly reduce its patient waiting list by March 2021. To achieve this there were a number of transformation projects being trialled, including virtual clinics and enhanced triage. The service was working closely with GPs to make them aware of appropriate referral criteria and reduce the number of inappropriate referrals. By effectively ‘triaging’ referrals consultants would be able to significantly reduce the number of patients who attended an unnecessary clinic appointment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. However, we were not assured that the trust was always open with staff when things went wrong. Whilst most staff felt there was a culture of openness within the trust, we found that learning from serious incidents had not been shared.

Staff told us they were proud to work at the trust and many staff had worked at the service for a number of years. Many staff told us they felt supported to develop their careers with the trust and were given opportunities to learn new skills. Staff spoke positively about their colleagues and their managers and told us they felt happy to raise concerns and share feedback.

Staff told us they felt there was an open culture within the trust, which was centred on the needs and experience of people who used the service. The trust’s ‘patient partners’ were encouraged to attend meetings within the service and were supported to contribute and ask questions. Managers encouraged staff to provide feedback and meeting minutes showed that this feedback was discussed and considered. Staff were focused on improving patient experience and were supported to raise concerns and suggestions for improvement.

The service took part in the annual NHS staff survey. Results for staff working in outpatients and appointment teams was mixed with some scores much worse than the trust average. For example, only 33% of staff felt involved in deciding changes that affected their work, compared to the trust
average of 51.5%. Whilst 94.7% of staff responded positively to say that they were encouraged to report errors, only 57.9% agreed that the trust would take action to ensure errors were not repeated.

The trust had responded by carrying out a series of cultural ‘audits’ with different teams to gain a better understanding of the issues raised within the staff survey. We asked to see any action plan in response to the staff survey but this was not provided.

Whilst most staff felt there was a culture of openness within the trust, we found that learning from serious incidents had not been shared with staff. Most staff were unable to tell us about any of the recent serious incidents which had impacted on patients within the service.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We asked the trust to provide examples of any recent compliance with duty of candour however this was not provided. Whilst investigation reports referred to considerations around duty of candour, action plans did not record that this had taken place.

**Governance**

Governance processes were not standardised or well-embedded. The service lacked effective systems and processes to assess, monitor and mitigate risks to the quality and safety of services being delivered. The trust recognised it needed to improve governance processes to enable effective oversight and management of safety and performance.

The trust told us that it had responded to challenges in achieving access targets by improving governance arrangements and increasing ‘operational grip’. The trust’s chief operating officer (COO) led twice weekly meetings to review all long-waiting patients. Speciality leads attended weekly waiting list review meetings to provide updates on performance and escalate any challenges. The deputy COO chaired weekly ‘access board’ meetings and divisional leads presented monthly performance reports to the board.

However, we found these governance processes were not well-embedded and lacked consistency and therefore did not provide effective oversight of performance and patient safety. Whilst these processes provided oversight of patients on the RTT pathway, it did not provide effective oversight of those patients who were waiting for follow-up appointments (non-RTT patients).

The senior team said responsibility for monitoring the ‘non-RTT’ patient waiting list sat with individual specialities, this meant there was a lack of central oversight of follow-up pathway delays. The lack of an effective governance process to provide central oversight of performance meant it was unclear how the trust gained assurance that patients waiting for a follow-up appointment were appropriately risk-assessed.

The trust lacked a standardised process across speciality departments to ensure patients were regularly reviewed for risk of harm or deterioration as a result of waiting for treatment. The trust recognised this as an area for improvement and had begun work to standardise this process.

Following the inspection, the trust shared their plan to improve governance of non-RTT patient waiting lists (patients who were waiting for follow-up appointments). However, the improvement plan showed that progress had been slow and the trust had not yet achieved corporate oversight of patients on non-RTT pathways. Work on this had started at the time of the inspection and was due for completion end of December 2019. However, as these improvements were not yet in place, the
service was unable to effectively assess, monitor and mitigate risks to patients waiting for an appointment.

We reviewed meeting minutes for a number of different governance and senior staff meetings and did not see any evidence of oversight of serious incidents and risk. SI investigation reports from February and March 2019 identified there were delays in investigation and sharing the learning from SIs. These included failures within the trust’s IT systems, ineffective or absent systems and processes to monitor patient pathways and failure to implement learning from previous SIs. Most staff we spoke with were not aware of these SIs and we did not see any evidence that learning had been shared. This meant opportunities to improve processes and prevent future similar incidents were missed. In addition, the delays in investigating SIs and failure to implement actions to address the root causes, had led to similar SIs reoccurring.

The senior team told us they used a recently developed performance dashboard to help monitor and review key performance indicators (KPIs). Whilst this included a range of performance data on metrics including clinic utilisation, staffing and incidents, it did not provide oversight of patient waiting times.

Senior staff told us the outpatient’s transformation programme was supported by a robust governance structure. The service had a detailed action plan with key milestones, delivery dates and action owners. As at October 2019, the plan showed that 86% of actions were either complete or on-track for completion. We were told the outpatient’s senior oversight group met monthly and was responsible for overseeing the implementation of the outpatient’s improvement programme. However, when we asked the trust to provide meetings minutes for this group, we were told the meeting was, “not run as a regular meeting with minutes” and therefore minutes were not available. It was therefore not clear how progress was being effectively monitored and recorded.

Management of risk, issues and performance

The service did not have a comprehensive system of assurance to ensure risks and performance issues were effectively reviewed, escalated and addressed. The trust recognised that current governance processes did not provide effective oversight of waiting time performance. Multiple serious incidents had highlighted gaps in validation and assurance processes and identified risks to patient safety. Whilst the trust had a plan in place to address these risks, the pace of improvement had been slow.

Arrangements for identifying, recording and managing risks and mitigating actions were unclear. The service’s senior leadership team told us that all outpatient service risks were recorded on the service’s risk register. However, some risks staff told us about, and those we identified during the inspection, were not recorded on the risk register.

Senior leads told us that the main risks to the service were staffing ad-hoc clinics, completeness of medical records and DNA rates. These were not reflected on the outpatient risk register. Other risks we identified during the inspection around equipment servicing and security of record storage were also not recorded. It was not clear how local issues and risks were monitored as meeting minutes we reviewed did not show evidence of discussion around risks or serious incidents.

The outpatient service risk register recorded just one risk relevant to King George Hospital. This related to the potential harm to patients due to ‘lost’ referrals due to an issue with the electronic referral system removing any patient who had waited longer than 180 days without an appointment. This had been on risk register since August 2018 and was now rated as low risk as controls had been put in place to ensure patients were identified before 180 days.
The trust had identified multiple serious incidents (SIs) in the 12 months prior to our inspection which had impacted on patient waiting times. Several incidents involved serious IT issues and raised concerns about data quality. The SIs revealed weaknesses in the effectiveness of systems and processes designed to validate the accuracy and completeness of patient waiting list data. Therefore, it was not clear how the leadership team gained assurance that systems and processes were effective in providing oversight of performance and risk.

The trust’s corporate risk register included five risks which related to waiting time performance, delays to patient care and the impact of problems within IT systems. All risks were allocated a risk owner, a review date and a risk rating. However, it was not clear where the recorded risks had been discussed before escalation to the risk register as meeting minutes we reviewed did not included any discussion on risks or incidents.

Three of these risks had been added to the risk register on 30 August 2019. We were told these risks had been added as a result of the recent serious incidents. However, as these incidents had been reported in February and March 2019, it was not clear why there had been a six-month delay in recognising these as risks.

Two risks had been rated as ‘high’ (amber) and one as ‘extreme’ (red). The risk that IT systems, and the use of these systems by staff, contain further issues that could result in further incidents and the risk that this could cause potential harm to patients by delaying their care, had both been rated as high. The trust had identified that multiple SIs related to the elective patient pathway could indicate there was insufficient workforce capacity to manage the patient pathway to discharge, this was rated as an extreme risk. However, it was not clear if this risk had been escalated to the board as we did not see any evidence of discussion of these risks within meeting minutes.

Whilst controls had been identified to mitigate these risks, these had not yet been fully actioned. Controls included establishing an overarching steering group to oversee the multiple SIs and introducing systems to track patient pathway, validation, clinical review and harm review process.

Senior staff told us that the trust had a process to identify the risk of deterioration or harm to patients, as a result of a long wait for treatment. However, we found this process was not well embedded and lacked consistency and therefore did not provide effective oversight of patient risk. This was because there was no standardised process across speciality departments to ensure patients were regularly reviewed for risk of harm or deterioration as a result of waiting for treatment. The trust recognised this as an area for improvement and had begun work to standardise this process. However, as this was not yet in place, it was not clear whether patients had come to harm through delays or long waits.

At the time of our inspection, not all clinical harm reviews had been completed, therefore the trust was unable to provide assurance that patients had not come to harm. Data provided for September 2019 showed that of the 1,823 patients selected for harm reviews, only 162 harm reviews (9%) had been completed.

The trust did not have an effective process to risk-assess patients waiting for follow-up appointments. We saw evidence that the trust had identified this as a concern in February 2019 and an SI had been reported. The initial SI indicated that 171,000 referrals, which were waiting for a follow-up appointment, were not being actively monitored.

At the time of the inspection, we were told the outcome of the investigation was not yet available. Although this issue had recently been added in August 2019 to the trust’s corporate risk register, at the time of the inspection we saw no evidence of action taken to mitigate the risk. In addition, senior staff we spoke with, within the outpatients service, appeared to be unaware of these risks. Due to a
backlog of outstanding clinical harm reviews the trust was unable to provide assurance that no patient had come to harm.

Following the inspection, the trust provided us with assurances that they were aware of these issues and were working with commissioners to make improvements. The trust had commissioned an external review into the SI and, following recommendations from this review, they had agreed with their commissioners an appropriate methodology to review patients who had been affected. We were told that as of November 2019, of 46,963 patients requiring review, 70% had been completed, with the rest due by December 2019.

The trust also shared with us their plan to improve governance of non-RTT patient waiting lists (patients who were waiting for follow-up appointments). However, the improvement plan showed that progress had been slow and that the trust had not yet achieved corporate oversight of patients on non-RTT pathways. In addition, work to standardise governance processes across specialities by implementing standardised patient waiting list meetings was not yet complete. Work on this had started at the time of the inspection and was due for completion on 30 January 2020.

Therefore, whilst we acknowledged the trust had a plan in place to address this risk, the pace of improvement had been slow.

**Information management**

The service did not have effective systems and processes to provide assurance over the accuracy and completeness of data. The trust had reported multiple serious incidents which highlighted weaknesses in IT systems and in processes designed to validate data. Therefore, senior staff could not be assured that performance data used to inform decision-making, was reliable. The trust recognised the serious risk that under-investment in IT systems could result in further serious incidents.

The trust had identified several serious incidents (SIs) in the 12 months prior to our inspection which had impacted on patient waiting times. Several incidents involved serious IT issues, one of which had resulted in a large number of letters and documents (43,000) not being sent out and another led to letters for 2,358 patients going to the incorrect address. Many of the incidents raised concerns about data quality and highlighted weaknesses in the effectiveness of systems and processes designed to validate the accuracy and completeness of data. It was therefore unclear whether the trust’s patient waiting list, and waiting time performance data, was an accurate reflection of the patients waiting for appointments at the trust.

Incidents highlighted problems with how information was transferred between the NHS electronic referral system and the trust’s patient administration system. One incident identified in July 2019, found that the algorithm the trust was using to assign a ‘clock-start date’ to these patients was generating inaccuracies in the patient waiting list data. This meant that for many patients’ waiting time was being inaccurately recorded. Whilst the investigation was on-going, it was estimated that over 4,000 patients had been affected by this error.

A similar SI, occurring previously, in February 2019, had affected over 1,600 patients. The investigation report had identified that the trust had no monitoring system in place to flag where there has been significant change in a patient pathway data. It also raised concerns that due to the size of patient waiting lists some services did not realize an issue had occurred, due to the number of patients on their waiting list. This highlighted that a lack of standardised process between specialities meant that not all services were carrying out patient tracking on a daily basis.
The appointments centre for the trust was based at King George Hospital and was responsible for booking first outpatients appointments for consultant-led clinics. We were told that, following a number of serious incidents in 2018/19, a number of improvements had been made to the administrative processes within the appointments centre. Improvements included restructuring teams, providing staff with customer experience training and independent review by NHS elect to review processes. Staffing levels had also been reviewed and aligned to call volumes to improve call handling performance and reduce waiting times and the number of abandoned calls. All outpatient appointment letters were delivered by an electronic portal system. The system enabled patients’ letters to be tracked and is stored electronically. Senior staff told us that following a recent serious incident where a significant number of appointment letters were not delivered, a daily report had been introduced which highlighted any letter that had not been issued. This enables the team to resend those letters manually. The outpatient’s senior leadership team monitored this through a weekly performance report which included number of dropped calls and failed letters.

The trust had reported seven serious incidents in the last 12 months related to information systems errors. The trust recognised the risk that their IT systems, and the use of these systems by staff, could contain further issues that could result in further incidents. The trust had highlighted that historical under-investment in resources to support new systems and process changes was a key contributory factor. There was no evidence of controls in place to mitigate these risks and therefore were not assured that there were effective systems and processes in place to prevent further incidents occurring.

The trust’s target for staff compliance with information governance training was 95%. Data provided by the trust showed that although all nursing and reception staff in outpatients had completed the training, only 86.8% of staff in the appointments team and 90.6% of staff in the clinic prep teams had done so. We saw that staff were not always following the trust policy and that patients’ records were not always kept secure from unauthorised people.

**Engagement**

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

The service was working closely with commissioners, GPs and patient partners to develop and improve processes to meet the growing needs of the patient population. The service had held a series of workshops to engage staff and stakeholders in quality improvement processes and to encourage innovative thinking around how services could be improved.

The service was working closely with GPs to make them aware of appropriate referral criteria and reduce the number of inappropriate referrals. By effectively ‘triaging’ referrals consultants would be able to significantly reduce the number of patients who attended an unnecessary clinic appointment.

The trust had recently announced plans to work more closely with the local mental health trust through a ‘group model’. This would support the development of integrated services with the aim of improving patient experience and access to services.

The outpatient service had a dedicated ‘patient partner’ who was also a trust volunteer. Their role was to act as the voice of the patient and represent patient views at a range of trust meetings and forums.
The service worked closely with a number of local organisations who provided support to patients with complex or additional support needs, including a service for people with learning disabilities and autism.

The trust took part in the annual NHS staff survey. Results for staff working in outpatients and appointment teams was mixed with some scores much worse than the trust average. The trust had responded by carrying out a series of cultural ‘audits’ with different teams to gain a better understanding of the issues.

Staff received daily updates at safety huddles. Managers took the time to recognise and thank staff for their work. Staff were invited to attend monthly ‘meet the chief’ sessions with the senior leadership team.

The outpatient service had developed a quarterly ‘keeping in touch’ newsletter which went out to all staff electronically. The bulletins shared updates about the service’s transformation programme, recruitment, feedback from the recent culture audits and training and development opportunities. However, we did not see any information shared on learning from incidents, risks or complaints.

**Learning, continuous improvement and innovation**

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. However, learning from serious incidents was not always shared with staff.

Staff could tell us about key improvements in outpatient services over the last 12 months and about further improvements that were planned. Future improvements included the introduction of a ‘patient portal’ which would allow patients to receive correspondence electronically and self-check-in kiosks in waiting areas. These initiatives were designed to both improve patient experience and improve efficiency in service delivery.

The trust was committed to using quality improvement (QI) methodology to improve patient experience and quality of care provided. Some staff had received training in QI methodology and had been encouraged to contribute to workshops to identify how processes could be improved. The head of administration and outpatient service manager have received advanced QI training to enable them to provide ongoing coaching and development for staff.

Whilst service leads told us how learning from recent serious incidents (SIs) had been used to drive improvements in systems and processes, learning had not been shared with staff. Most staff we spoke with were not aware of these SIs and we did not see any evidence that learning had been shared. This meant opportunities to engage staff in improving processes and prevent future similar incidents were missed.