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**

**Acute hospital sites at the trust**

A list of the acute hospitals at the 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>King George Hospital</td>
<td>Barley Ln, Goodmayes, Ilford, IG3 8YB</td>
<td>Accident and Emergency</td>
<td>Barking, Goodmayes, Ilford, Collier Row and Chadwell Heath</td>
</tr>
<tr>
<td>Queen’s Hospital</td>
<td>Rom Valley Way, Romford, RM7 0AG</td>
<td>Accident and Emergency</td>
<td>Romford, Upminster, Havering, Harold Hill and Hornchurch</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites Acute tab)
Is this organisation well-led?

We rated Well Led at Barking, Havering and Redbridge NHS Trust overall as requires improvement.

Leadership

Board Members

Of the executive board members at the trust, 20% were Black Minority Ethnic (BME) and 40% were female.

Of the non-executive board members 33.3% were BME and 33.3% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>1 (20.0%)</td>
<td>2 (40.0%)</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>33.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>27.3%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

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

The trust board included executive and non-executive members with a range of experience, knowledge and skills appropriate to their roles. We found that as a group, the board had a wide range of private and public sector experience, and a variety of skills that enabled them to perform their roles.

The chief executive, Matthew Hopkins, had been in post since April 2014. The trust chairman, Joe Fielder, had only recently taken on the role as of November 2017 and was also chair of another London NHS foundation trust.

The executive team comprised of: chief executive, chief nurse, medical director, (interim) chief operating officer, (interim) director of finance and investment, director of people and organisational development, director of strategy and infrastructure, and director of communications and engagement.

In the 12 months prior to our inspection, the chief executive, medical director and director of people and organisational development had taken long periods of leave due to illness, but had since returned to work. At that time, the substantive director of finance had taken on responsibility as acting chief executive. Arrangements had also been made to cover the medical director whilst on sickness absence which were regularly reviewed.

The previous director of finance and two other substantive members of the executive team had since left the trust to pursue promotion.

The current interim chief operating officer had been in post since January 2018 and had previously worked at the trust for ten years in a number of different leadership roles. Recruitment for a substantive post was to commence in April.

The interim director of finance and investment had been in post since January 2018.
At the time of our inspection the position of deputy chief executive was not in place. This was to be reviewed once interim posts on the board had been made substantive.

The non-executive directors comprised of seven individuals of varying backgrounds and experience (including the chair). Individual responsibilities amongst the non-executive directors included chairing the following committees and groups: Finance and Investment Committee, Audit Committee, Quality Assurance Committee, Chair of People and Culture Committee; as well as leading the Equality, Diversity and Inclusion Steering group. Despite the varied experience that was shared by the non-executive directors, senior staff expressed concern that finance and accountancy experience was one area that could be strengthened, as only one non-executive director had experience as a chartered accountant.

The board had overall responsibility for monitoring quality of performance and finance. Both executive and non-executive directors recognised that the period when the chief executive, medical director and director of people and organisational development were on sick, along with the other changes among the board, had created some instability that had impacted progress and effective governance in these areas. The medical director told us he recognised that arrangements for cover during his absence should have been better.

The trust was placed in to financial special measures by NHS Improvement (NHSI) in February this year. When discussing this with members of the executive and non-executive team it was clear that prior to this the board did not have sufficient oversight or understanding of the issues which led to financial special measures. Internal and external reviews had been commissioned and steps had been taken by the board to better understand the risks.

From our conversations with the non-executive directors, it was possible to see how they were involved in influencing the overall leadership of the trust. There was evidence of constructive challenge on the board which we also observed at a board meeting. However, they recognised that further improvement was needed to ensure that they had sufficient oversight of organisational risks. Since the appointment of the chair, the board was now scheduled to meet more frequently: ten times a year instead of six and more time was assigned to ensure that matters were thoroughly considered.

The trust had a current fit and proper persons policy and checks were in place. 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 (FPFR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5).

Staff commented that the executive team were predominantly visible and approachable. The chief executive was well liked and respected amongst staff we spoke with. Nursing and midwifery staff told us that the chief nurse was supportive, providing strong leadership and guidance. Non-executive directors would visit wards and clinical services; however a structured programme for visits was not currently in place. The chief executive held regular ‘breakfast with the boss’ meetings with staff and the chief nurse held afternoon tea meetings. The chair also had an ‘open-door’ policy where all staff were encouraged to come to him if needed. However, prior to and during the course of our inspection, we were approached directly and received a number of correspondences from consultants at the trust, expressing concern at a lack of confidence in the trust executive team to engage and acknowledge their concerns.

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 officer. The six divisions were: acute medicine, anaesthetics, cancer and clinical support (including outpatients), specialist medicine, surgery, women and child health.
Divisional directors were able to evidence a collaborative approach to working together, and convey what the current issues of concern and organisational risks were. Despite the recent instability amongst the senior leadership, the divisional directors confirmed that quality had remained the overarching agenda priority and were supportive of the chair and the chief executive being back in post following his absence.

The trust Medicines Optimisation and Hospital Pharmacy Transformation board was led strategically by the chief pharmacist. This ensured that medicines concerns were visible and regularly considered at trust board level. A number of key areas were regularly discussed, for example, how technology could be utilised to improve medicines optimisation.

The trust had developed a four-tiered management and leadership development programme with the aim of developing both the skills and the behaviour to align staff with the values of the trust. The four programmes were aimed at senior leaders, divisional leaders, middle managers and aspiring managers. Accreditation was available to those who wanted to aspire to the next level. The trust had also developed training programmes for nursing management development, aimed towards ward managers and matrons. The trust had launched an initiative in November 2017 to make clear the expectations of staff in leadership position and how they could be best supported to work in line with the trust values.

These learning programmes were intended to address the need for succession planning. A talent management and succession planning strategy was in development. Data provided by the trust before our inspection showed that in total 69 staff had attended leadership programmes commissioned via divisional teams, in addition to the leadership programmes commissioned in-house.

**Vision and strategy**

In 2015, the trust was one of four other NHS trusts in the country identified to work in partnership with an external organisation that helped support quality improvement. The trust had since developed a clear vision and set of values. Entitled ‘The PRIDE Way’, the methodology incorporated the trust values of passion, responsibility, innovation, drive and empowerment; emphasising person-centred care and an evidence-based quality improvement culture.

Staff across the trust were able to articulate the PRIDE values and the trust used different methods to ensure these were embedded in staff. This included aligning staff appraisals, staff induction and staff recruitment with the trust values.

The trust had set five key objectives in 2016 to be reviewed after two years: delivering high quality care; running the hospital efficiently; becoming an employer of choice; managing finances, and working in partnership. Since exiting quality special measures in 2016, the trusts’ strategic focus had moved towards establishing resilience and longer-term stability. Development of this strategy had been aligned with the NHS’s Five Year Forward View that recognises the need to further prevent avoidable illness, provide a wide range of services to meet the needs of the population, improve the efficient use of finances to deliver this.

The trust strategy was communicated to staff via the website and disseminated through emails and social media feeds. Staff we spoke with during our core service inspections 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 we spoke with were also varied in their understanding of the overall strategy and direction that the trust was heading.
The strategic vision for King George Hospital (KGH) to become a centre of excellence for elective care, long term conditions and care of the elderly remained; although it was recognised that increased demand on emergency services at KGH meant that plans to close the emergency department and develop an urgent care centre were no longer viable.

The strategic plan was for Queen’s Hospital (QH) to become a centre of excellence for emergency and maternity care, and care of children and young people. The emergency department was currently going through a reconfiguration and had experienced consistently high numbers of attendances over the winter period that had stretched the service.

The trust worked closely with another NHS foundation trust that delivered community health and mental health services to the wider area. The broader strategic health plan for Barking and Dagenham, Havering and Redbridge included integrating community and acute services to provide a more joined-up approach to the delivery of health care.

Instability amongst the board and recent concerns around the financial governance of the trust raised concern as to the viable delivery of the trust strategy. In the autumn of 2017, the board was formally advised that it was off plan in meeting its year-end financial control total. The trust had since been placed in to financial special measures as of February 2018. The senior leadership team expressed concern that plans to recover the trust financial position carried the risk of impacting quality.

Culture

Staff we spoke with during our core service inspections and in focus groups recognised the work the senior leadership team had done over recent years to improve staff morale and recognise the value of its workforce. Staff cited the introduction of the PRIDE values and greater visibility of the executive team as important factors.

However, there were pockets of staff we spoke with where morale was low and perceived executive team engagement was not sufficient. We carried out our core service inspection across the trust at a time of high winter pressure. Staff we spoke with during our inspections commented that vacancy levels were impacting some teams despite improving vacancy rates across the trust. Staff also voiced concern as to how much longer staff resilience could hold out under ongoing operational pressures. Senior leaders were concerned at this and examples were told us where senior clinical leaders cancelled meetings and worked clinically to support as appropriate.

Nursing and midwifery staff we spoke with mostly spoke with strong support and clear leadership, both at divisional and executive level. Despite the challenges, most staff were positive about working with the trust and with the senior leadership team. A focus on management and leadership development amongst staff had been initiated to improve staff retention and in the previous months of our inspection, attrition rates amongst clinical staff had improved. There was also an emphasis on developing newly qualified nurses who chose the trust as their place to work who now stayed at the trust in greater numbers and for longer after qualification.

Prior to and during the course of our inspection, we were approached directly and received a number of correspondences from consultants, voicing concern of a culture of bullying, as well as expressing a lack of confidence in the trust executive team to engage and acknowledge their concerns.
The trust had initiated a process of engagement with the consultant body so as to better understand and resolve these concerns. This process had also led to the commissioning of an independent review.

The trust recognised that 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.

Conversations we had with members of the board, divisional directors and other staff members across the trust highlighted concern that the accusations of bullying and disengagement were not reflective of the consultant body as a whole but were isolated to a small faction of consultants. Predominantly, the medical director received support from colleagues across the trust; however, it was recognised that changes in leadership style and approach were needed to help improve overall engagement.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group. Percentages presented are a proportion of all staff working at the trust as a whole; therefore the percentages presented do not add up to 100%.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and Midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4.9%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.5%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Asian</td>
<td>5.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Black</td>
<td>1.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Chinese or other ethnic group</td>
<td>0.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>1.1%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

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

The trust were keen to build upon the work that had already commenced to promote equality and diversity. A motto had been introduced in 2017: ‘We are diverse. We are inclusive. We are you.’ The aim was to further raise profile across the trust.

A number of staff networks had been established to help provide support and promote equality. This included: BME network; Personal, Fair & Diverse Champions network; LGBT and Disabled Staff network. An Equality, Diversity and Inclusion Steering Group chaired by a non-executive director was set up to oversee their progress. However, staff we spoke with perceived that there needed to be more emphasis and ownership of staff networks from senior leaders.

The trust further encouraged staff to celebrate diversity through individual events that were open to all to partake in; for example, celebrating Diwali through sharing of traditional food. The trust had also promoted the NHS Employers Personal, Fair and Diverse campaign and had identified 52 champions across the trust to further raise awareness towards equality and diversity.

The trust had five key findings that exceeded the average for similar trusts in the 2016 NHS Staff Survey:
### Key Finding

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>4.15</td>
<td>4.05</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>4.04</td>
<td>3.94</td>
</tr>
<tr>
<td>Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.08</td>
<td>3.96</td>
</tr>
<tr>
<td>Percentage of staff agreeing that their role makes a difference to patients / service Users</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>Quality of appraisals</td>
<td>3.29</td>
<td>3.11</td>
</tr>
</tbody>
</table>

Mandatory training levels amongst medical staff were lower than the trust target and did not align to the appraisal rate. Medical appraisal covered job planning, quality performance indicators, professional development and mandatory training. Despite the NHS trust survey highlighting that quality of appraisal at the trust was better than the national average, there was concern that medical appraisals were completed without sufficient consideration as to whether mandatory training had been completed.

The trust has five key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>Percentage of staff who experienced physical violence from staff in the last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Percentage of staff who experienced discrimination at work in the last 12 months</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Percentage of staff who witnessed potentially harmful errors, near misses or incidents in the last 12 months</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>45%</td>
<td>51%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2016 - link)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.
Of the four questions above, two showed a statistically significant difference in score between White and BME staff:

- Percentage of staff who believed that the organisation provides equal opportunities for career progression.
- In the last 12 months have you personally experienced discrimination at work from manager or team leader or other colleagues?

The trust set up a BME staff network in 2016 and had actively promoted equality and diversity. This had been championed by the chief executive and the director of people and organisational development. At the last inspection in 2016, staff had commented positively on the steps that had been taken. Over the last year, there was a perception amongst staff that progressing BME staff development had slowed when both the chief executive and director of people and organisational development had been absent due to sickness.

When discussing this with the senior leadership team and the lead for equality and diversity, it was agreed that greater emphasis and leadership from the board was needed to drive the equality, diversity and inclusion strategy. The challenges around culture and staff retention were reflected on the corporate risk register. Priorities for equality and diversity moving forward were in delivering leadership programmes and creating positive and inclusive culture amongst the workforce, recognising that some staff still did not perceive that the trust promoted equal opportunities.

During our core service inspection we received feedback from staff that managers and team leaders were mostly supportive, promoted trust values and valued their teams. Most staff were confident to speak up and seek advice when necessary.

Managers encouraged an open culture to reporting incidents without blame. We conducted a review of incidents and complaints and saw evidence that the trust was committed to and responded appropriately to the statutory duty of candour. Where an incident met the requirement of the duty of candour we saw evidence that the trust met the regulatory requirements.

The trust had a Freedom to Speak up Guardian service. The existing guardian had been in post since 2013 when the service was first developed at the trust as a pilot. Staff gave a variable
response when asked if they were aware of this role, but knew that there was a whistleblowing policy that they would feel willing to use when necessary.

Since 2015, and following changes to the senior leadership team, a more open and honest culture had been fostered at the trust. Many staff we spoke with said they were happy to raise concerns with their immediate management team and were confident they would receive support.

The trust encouraged the Freedom to Speak up Guardian service and monitored the data as to how many accessed the service. However, following a review, we raised concern with the senior leadership team that the service was not sufficient enough in ensuring staff were able to confidently and impartially raise concerns and access support. The guardian service also did not provide sufficient assurance they were effectively monitoring the outcomes of the service and that concerns raised via the service were being effectively followed through.

The 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 feedback on their experiences of care and treatment. The trust developed the FFT to include further questions that would help gather better intelligence and understanding of staff experience.

The trust scored below the England average for recommending the trust as a place to receive care from November 2016 to October 2017.

(Source: Friends and Family Test)

The top concerns highlighted by the 2017/18 staff FFT across a number of core services was: staff not being able to recommend [the trust] as a place to receive care; staff not being able to recommend [the trust] a place to work; staff not believing [the trust] provided equal opportunities for career progression or promotion; staff experiencing discrimination at work in the last 12 months; staff satisfaction with opportunities for flexible working; staff witnessing potentially harmful errors, near misses or incidents; staff experiencing physical violence from staff in last 12 months.
The trust had considered this information against the staff annual survey where the following issues were highlighted: staffing levels and the impact of these on patient safety and staff wellbeing; the need for further personal and professional development; the need for managers to act on staff feedback; staff wanting to be supported and for there to be appropriate work/life balance; Personal Performance Reviews - staff would like these to be done early in the cycle, with more time set aside and follow through on commitments; for feedback to be acted on; fairness with regards to recruitment and selection and a level playing field for staff to progress their careers; targets and finances need to be balanced with quality of care.

The trust’s sickness absence levels from September 2016 to July 2017 were below the England average.

(Source: NHS Digital)
In the 2016 General Medical Council Survey the trust performed worse than expected for two indicators (Induction and Feedback) and the same as expected for the remaining 12 indicators. (Source: General Medical Council National Training Scheme Survey)
Governance

The trust had in place governance processes to ensure quality and performance processes were reviewed and escalated. The board was informed by a number of committees where issues and papers, including the Board Assurance Framework (BAF) were considered.

Following previous inspection, the trust had taken steps by working in partnership with an external institute to improve its quality governance structure. This had led to a number of changes and improvements. Since our last inspection, we found that overall governance had improved across the trust, although we were still concerned that there were pockets where systems and processes were not as effective as they could be in managing risk. This was highlighted by the recent concerns around financial governance. However, when we discussed this with the chair and the chief executive they explained that changes had since been implemented to ensure greater transparency of risk. A review of board and committee papers and further conversation with the non-executive directors confirmed that the quality of information presented to the board had improved.

Progress and risks to delivery were reported to the board through the following groups/committees: Trust Executive Committee (TEC), Quality Assurance Committee, Audit Committee, Finance and Investment Committee, People and Culture Committee, Quality Governance Steering Group, clinical quality review meeting with local commissioners. The Quality Assurance Committee, chaired by a non-executive director, met monthly and was the lead committee for quality and safety.

Quality objectives were overseen by an executive director whose responsibility it was to ensure the right support and progress was reviewed. The medical director and chief nurse held responsibility for delivery of the clinical priorities, whilst direct operational priorities were the responsibility of the chief operating officer.

In each division, team meetings fed up to specialty level and on to the Divisional Operational Board. This group then reported to a performance review panel, which reported to the TEC, chaired by the chief executive, which in turn reported to the board.

The TEC met to discuss all quality, workforce, performance, financial and partnership indicators. This committee included executive directors, divisional directors, and corporate leads for finance, workforce and quality.

Quality assurance data was collated and received by the Quality and Safety Committee via a dashboard. Each clinical division presented quality and safety reports at board and committee meetings. Four specific sub-groups had been established to feed in to the Quality Assurance Committee via a quality governance steering group. These were: patient safety group; clinical outcomes and effectiveness group; patient experience and engagement group, and risk and compliance group.

Risks were appropriately reported on the trust-wide risk register and high level risk registers (containing risks scoring 15 and above) and were monitored via the quality governance steering groups and sub-groups, divisional quality and safety groups. Strategic risks, which could prevent the trust from achieving corporate objectives, were recorded on the BAF which was monitored at board.
Risk management was managed via the risk and compliance group which reviewed risk management at division and specialty level. Divisional risks were reviewed as part of monthly divisional performance review meetings.

Medicines optimisation was well integrated into the governance structure for the trust. The chief pharmacist was accountable to both the medical director and a divisional director. Medicines issues were reported from various committees up to the board level quality assurance committee.

Service providers of homecare services were regularly audited. A sub-category was added to incident reports to identify those specifically relating to homecare so that areas for improvements could be identified.

Prior to our inspection, the board had scheduled to meet six times a year. Following the appointment of the chair in November 2017, this had been reviewed and now the board were to convene ten times a year to ensure that there was greater oversight of organisational risks.

The trust provided their Board Assurance Framework (BAF) which detailed five strategic objectives and accompanying risks. A summary of these is below:

1. Delivering high quality care
2. Running our hospitals efficiently
3. Becoming an employer of choice
4. Managing our finances
5. Working in partnership

(Source: Trust Board Assurance Framework)

Each division completed a risk register which informed the BAF. On review, the BAF was appropriately set out and collated, although didn’t include an initial score for each risk. Mitigation and controls for a variety of risks were examined and were recorded appropriately, and reasons for reducing scores were suitably given. Although an area for improvement was once a risk was downgraded, it was not clear as to how the risk was monitored to ensure oversight of a similar problem returning at a later date.

Management of risk, issues and performance

Prior to our inspection, the trust provided the following summary of their financial performance:

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical Data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous financial year (2 years ago) 15-16*</td>
<td>Last financial year 16-17 *</td>
</tr>
<tr>
<td>Income</td>
<td>£505.5m</td>
<td>£558.3m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£33.7m)</td>
<td>(£10.9m)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£539.2m</td>
<td>£569.1m</td>
</tr>
</tbody>
</table>
Budget deficit

| (Budget deficit) | (£34m) | (£11.9m) | (£0.2m) | £8.7m |

Income includes both operating and non-operating revenue.
* Excluding Impairments and IFRS adjustments
* ^ Agreed NHS Control total. ~ Agreed Control total plus STF Shortfall

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

However, in November 2017 the board discovered that the projected financial end of year budget deficit was much worse than had been anticipated. The trust were made aware of worsening performance against the Public Sector Payment Policy. There had been insufficient oversight of payment to creditors. An external assessment of the financial situation was commissioned and was ongoing at the time of our inspection.

The trust independently funded a review of the financial governance arrangements using a third party accountancy consultant. We were told that the causes of the deterioration in finances were considered in part down to over spending in areas such as temporary staffing, unfunded over performance on commissioner contracts, slippage on quality and cost improvement plans and the correction of a backlog in unpaid suppliers.

Insufficient escalation of concern around cash flow challenges; inadequate reporting and monitoring; inadequate response to the financial risk, and instability on the board during 2017 were cited as issues that culminated in the current financial position. Following review, it was recognised that there were indicators that should have raised concern but were not identified.

Recently, the board had put in place a more thorough review of the trust finances, challenging the quality of data and providing more detailed scrutiny. The chief executive when asked stated that he was confident that present processes would highlight concerns. However, there remained the risk that financial recovery would impact quality and this concern was shared amongst most members of the board who we spoke with.

During our core service inspections we found service leaders met monthly to review risks, serious incidents, incident reporting and complaints, and identify responsibilities. A risk management strategy was in place that considered risks within services. Monitoring of morbidity, mortality, key performance indicators and other significant service indicators was achieved using a service level dashboard.

Service level risk management plans were underpinned by a schedule of audits. The trust provided evidence of 101 clinical audits that had been conducted during the reporting period. Key concerns and actions were evidenced. Where risks were identified, recommendations were made to improve standards and mitigate risks. Risk registers were found to align with staff concerns.

A number of medicines audits were completed to improve medicines safety and effectiveness. For example, controlled drugs, medicines reconciliation, allergy status, and the omission of doses were audited. Patient safety alerts were dealt with and disseminated by the central governance team. Any medicines issues identified during inspection were already listed on the trust risk register. For example, during the core service inspection, difficulties in maintaining suitable temperatures in medicines storage areas had been identified. However, the chief pharmacist was already aware and had started work to investigate solutions. As a result, additional staff training was provided and additional temperature monitoring checks were implemented.
The trust had a medication safety officer (MSO), as well as a ‘safe medicines practice group’. This group was embedded in the medicines optimisation plan and ensured learning from medicines incidents was shared. The MSO regularly attended meetings with medication safety officer colleagues from other London organisations.

Good practice was also implemented from other hospitals by working with colleagues both within and outside London. The trust was also engaged in providing information to external bodies relating to medicines incidents and performance (such as the NHS England Medicines Optimisation dashboard).

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority.

The trust provided a document detailing their 14 highest profile risks. Each of these has a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Variation on the application of standardised care.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>1.4</td>
<td>Failure to recruit and retain sufficient staff with appropriate capability, capacity and behaviour to deliver transformed services.</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>1.5</td>
<td>Potential lack of leadership capacity, capability and performance will undermine improvement.</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>1.6</td>
<td>Inability to deliver the operational plan</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>1.7</td>
<td>Churn in Board membership, leading to concerns over stability</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>2.2</td>
<td>Ensuring we have the capacity to deliver the activity we agree with commissioners.</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>2.3</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>
</tr>
<tr>
<td>2.4</td>
<td>Failure to develop new ways of working that deliver recurring savings, whilst maintaining the quality of care.</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>3.1</td>
<td>If we cannot achieve and embed the necessary cultural change, we will not be able to transform our services and maintain high standards of care, preventing us from becoming an employer of choice.</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>4.1</td>
<td>Commissioner inability to fund activity within the payment by results (PBR) contract.</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)
In accordance with the Serious Incident Framework 2015, the trust reported 148 serious incidents (SIs) which met the reporting criteria set by NHS England between Sept 2016 and Sept 2017.

During the reporting period, medical care had the highest number of STEIS reported incidents at 49 followed by surgery (29 incidents), maternity (19 incidents), and urgent and emergency care (11 incidents).

All incidents were reported on the trust’s risk management database. The quality and safety team reviewed all incidents on a daily basis. Serious incidents (SIs) were identified and then escalated to the deputy chief nurse. The relevant division 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.

Improvements to this process were recognised and a workshop had led to the trialling of an immediate huddle as soon as an SI was reported, with a view to gathering information and initiating action much earlier on.

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 every Thursday 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 four serious incident reports selected at random, and noted that they were clearly laid out and easy to read and understand. Each report included a summary, index and contents page. There was evidence that investigations were expertly led and credible and a focus on learning was prioritised.

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.

Following leaving quality special measures the trust reported three never events in four months from March 2017 to June 2017. These related to retained foreign object in surgery. The trust provided details of investigations into these cases, and carried out external quality reviews. Learning from these incidents was shared in divisional quality and safety meetings. During our inspection of surgery services we saw evidence that action had been taken to further strengthen use of WHO guidelines in theatre. A policy had been further developed and regular auditing was in place to monitor staff compliance.

**Information management**

The trust captured data through the use of clinical dashboards and key performance indicators that were used to inform the board via a number of committees and groups. The board received a varied amount of information to help advise them as to quality and sustainability.
Service level performance measures enabled clinical staff to monitor activity and clinical outcomes. This was discussed at monthly service led quality and safety meetings, where concerns were escalated to the Quality Assurance Committee.

Service leads had access to variety of quality and operational information to help manage their services, such as in assessing performance, reviewing staffing and quality of patient care.

The trust had in place a team of information specialists to provide internal analytical support and ensure external reporting obligations were met. Data quality was overseen by a Data Quality Assurance team who were responsible for monitoring and improving the quality of information in the trust. A Data Quality Monitoring Team worked alongside the Data Quality Assurance team, to review and amend incorrect data.

The trust was required to submit notifications to external bodies, including CQC, which they had been compliant in. Commissioners spoke of improved relationship with the trust and confidence in the quality data that was shared with them.

The trust were compliant with information governance (IG) standards and utilised the IG Toolkit to assess themselves. There had been no information governance incidents that were reportable to the Information Commissioner’s Office (ICO) in the last year.

Following the recent financial challenges, the trust had to re-evaluate the financial information that was being presented at board. We were told by the executive directors that there was now greater transparency and scrutiny and this was evidenced in board papers. However, there remained concern as to financial visibility at divisional level, with management teams reporting that they often only received expenditure data, without access to income data – this meant that the divisional management were operating with partial information. Conversations with the senior leadership team confirmed that further work was needed to assure the quality of financial information escalated to board. An external review had been commissioned that was still ongoing at the time of our inspection.

IT systems were not aligned to record and provide accessibility of information effectively. This was evidenced across services where we found different systems to record patient information, including the use of paper records. Staff told us that this was frustrating.

Pharmacy staff accessed summary care records and used this information to conduct medicines reconciliation. Staff could access trust medicines policies online, and reported that this system had improved. Electronic prescribing was implemented in oncology in line with national guidance. There was a plan for electronic prescribing to be implemented across the trust by October 2018, however finance remains an obstacle.

Pharmacy staff were working with IT to develop a medicines outcomes database and make processes for data collection more sophisticated. Data was shared with the trust board with regards to medicines statistics, for example the model hospital report.

The trust utilised email and social media to disseminate information to staff. Staff could also access information via the intranet, where links were available to policies and standard operating procedures.

Following inspection, we were made aware by the trust that it had discovered a possible backlog of consultant letters on the electronic patient records system that had not been issued. The trust has initiated an investigation. We will be monitoring the progress of the investigation with the trust.
Engagement

There were a number of initiatives in place to give staff the opportunity to meet with the senior leadership team. For example, the chief executive held regular ‘breakfast with the boss’ meetings with staff and the chief nurse held afternoon tea meetings with staff, as well as met weekly with matrons, senior sisters and divisional nursing staff. Other trust directors, including the chair, had an ‘open door’ policy so that staff could feel confident in approaching senior leaders to share their concerns.

A weekly staff e-newsletter and a monthly ‘team brief’ bulletin were disseminated to staff. Some staff we spoke with had concern as to the effectiveness of these ways of communication, particularly when staff were busy and unable to access a computer.

There was an increased focus on developing opportunity for staff development. Staff commented that overall morale was good and staff felt a part of the direction that the trust was travelling in. However, there were pockets of staff across different core services that suggested more could be done to include staff across different bands and roles in planning the delivery of services.

A number of consultants had raised dissatisfaction with the level of engagement that they had received from the executive team, particularly in relation to car parking, job planning and staff appointments. The chair, chief executive and medical director stated they had listened to their concerns and a plan for engagement had been initiated and proposed to the Senior Medical Staffing Committee. An independent review to better understand the reasons for dissatisfaction in the consultant body had also been commissioned. This was ongoing at the time of our inspection.

Pharmacy staff worked collaboratively with CCGs. Board papers were shared to ensure that other trusts were aware of decisions being made in the trust with regards to the use of medicines. The chief pharmacist was National Institute for Heath and Care Excellence (NICE) associate and used the links to support medicines optimisation within the trust. The trust was linked with the NHS London Procurement Programme and was aware of medicines initiatives that required implementation within the trust.

The trust jointly worked with a local NHS community and mental health provider in delivering a staff conference where the importance of diversity and inclusion for health care providers and large employers could be considered. The trust also partook in the annual Dignity at Work month in July 2017 and Black History Month in October 2017. We saw and heard evidence that the trust was committed to engaging staff in improving a culture of equality, diversity and inclusion. However, they acknowledged that recent staff survey results highlighted that more was to be done in addressing the number of staff who experienced discrimination and harassment; did not believe the trust provided equal opportunities for career progression, nor recommend the trust as a place to work.

The trust had developed services and support for people with learning disability and their families. This had included training over 80 staff to be learning disability champions in the trust, increasing awareness, as well as improving access to services.

The trust had a number of forums to allow patients and the public to give feedback. These included the annual general meeting, public listening events, social media and a local representative’s panel. Trust board meeting minutes were published on their website. Improvements to the trust website made it easier for patients and the public to share their opinion.
The trust had developed their patient experience strategy in 2016 through engagement with the local community.

A patient partners group was established to ensure understanding of patient experience was considered when developing services. This group spoke positively of how the trust included them and listened to their opinion. An important part of their role was to talk with and listen to patients and ensure that their voice was represented. A deputy chief nurse attended their meetings.

Patient stories were an important part of how the board listened to the patient experience, and were at times presented in person at board meetings.

The cancer patient survey 2016/17 showed improvements in patient care to the previous survey: 91% of patients thought their overall care was good or very good; a six per cent increase from what it was in 2015, and above the national average of 89%. Asking patients to rank their hospital experience from zero to 10, the average score was 8.8, an improvement on the previous 8.5, and 0.1 higher than the national average. There was also improvement with more people saying they were given clear information about their diagnosis (74%) and said they had enough privacy when discussing their treatment (86%).

However, areas for improvement were identified: 66% of patients said they had confidence in all the nurses on the ward, compared to the 74% national average; patients did not always feel they were given clear information about whether their radiotherapy (50%) or chemotherapy (61%) was working to get rid of the cancer.

Communication with stakeholders and other regulators was improving and it was recognised that the trust was working hard to foster clear and open relationships. Prior to our inspection, the trust had participated in completing a quality and risk profiling tool that allowed a number of stakeholders to come together and present the information that they held about the trust and discuss concerns and risks.

The trust worked closely with the local Healthwatch teams (HW) who carried out ‘enter and view’ visits to the trust to review the environment and talk to patients and relatives. HW provided feedback to the trust who in turn would consider what action to take in response. HW acknowledged the quality improvements that the trust had made in a number of areas, including closer partnership working.

The trust chair was also chair of another London NHS foundation trust that delivered community and mental health services to the boroughs of Barking & Dagenham, Havering, Redbridge and beyond. The trust had a longer term strategy to be part of greater service integration across the sustainability and transformation partnership (STP) area that both trusts provided services for. Having a common chair was proving beneficial in promoting a closer working relationship across both providers.

**Learning, continuous improvement and innovation**

The trust had utilised a quality improvement methodology to develop its values and implement an evidenced-based improvement culture. When introduced, the PRIDE Way methodology brought a change in emphasis to how the trust would operate. Three core principles were agreed to underpin the trust values. In summary, patients were the first priority; staff were to be trained in improvement methodology and empowered to identify and make changes; improvement would be continuous and incremental.
Quality improvement initiatives entitled ‘value streams’ had recently been introduced. These sought to engage and train frontline staff to be equipped to better the service they worked in. For example: focusing on first 24 hours for frail, elderly patients; diagnostic processes; discharge processes, and learning from patient safety incidents.

Staff across core services were encouraged to use this quality improvement model and be research active. For example, as of February 2018 there were 45 live research projects in medicine. This included in cardiovascular, dementia, neurological, skin, diabetes, oral and gastrointestinal, hepatology, metabolic and endocrine, respiratory and stroke services. A quality improvement lead for respiratory medicine worked with junior doctors and nurses to design and deliver research programmes that improved patient care and outcomes. We looked at two research programmes carried out in medical care and saw they were structured against ‘plan, do, study, act’ (PDSA) research methodology and carried out in the context of NICE clinical guidance.

Following exiting quality special measures in 2016, the trust strategy had been focused on further establishing quality improvement. Despite some good examples, we did not find that this had been fully embedded across all core services at the time of our inspection.

The trust recommenced reporting of referral to treatment times in November 2016 after undertaking 5000 extra operations and 95,000 outpatient appointments to tackle the backlog. A governance structure that oversaw delivery of referral to treatment times (RTT) had been established that worked closely with other regulators to provide assurance and ensure progress was maintained. In March 2017, the trust hosted a RTT conference where lessons learnt were shared with other NHS organisations.

There was a weekly ward pharmacist development group which included training from internal and external trainers. There were systems to support continuous improvement and innovation. In addition to training opportunities, data obtained was used to benchmark performance against other trusts. Patient safety messages were sent out and discussed at patient safety summits.

The trust worked with other organisations to learn from them, and information was shared via the national medicines safety network for other trusts.

The role of pharmacy technicians was extended to include preparation of discharge prescriptions. This was an innovative use of their skills and much appreciated by doctors because it saved time. Pharmacy technicians were also able to use their medicines reconciliation knowledge to identify and reduce medicines wastage.

The trust used external reviews to learn from incidents and improve services. The trust had also commissioned a review of their governance structure and had initiated changes in response. At the time of our inspection an external review had been undertaken to better understand the cultural challenges and concerns that had been raised by the consultant body.

Divisional teams were encouraged to drive improvement and regularly take time out to review individual and team objectives, processes and performance. However, not all divisional team leaders felt that this was supported enough and expressed concern as to the sustainability of quality improvement within the trust.

The trust recognised that more was to be done to better identify risks through their internal processes rather than relying on external parties to identify key risks before they start to be addressed.
The trust was asked to comment 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>25-40 working days</td>
<td>Q2 98% of all complaints responded to on time</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 working days when joint with an SI</td>
<td>Q2 98% of all complaints responded to on time</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>2,378 between October 2016 and September 2017</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Completing* defined as closing the complaint, having been resolved or decided no further action can be taken

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

The trust received 741 complaints from October 2016 to September 2017. Medicine core service received the most complaints with 258.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>258</td>
<td>34.82%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>177</td>
<td>23.89%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>140</td>
<td>18.89%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>61</td>
<td>8.23%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>45</td>
<td>6.07%</td>
</tr>
<tr>
<td>Trust</td>
<td>22</td>
<td>2.97%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>22</td>
<td>2.97%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>6</td>
<td>0.81%</td>
</tr>
<tr>
<td>AC - Ambulance Services</td>
<td>4</td>
<td>0.54%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>3</td>
<td>0.40%</td>
</tr>
<tr>
<td>CHS - Adults</td>
<td>2</td>
<td>0.27%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>1</td>
<td>0.13%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab - link)
The trust complaints team consisted of a head of complaints, PALS and family liaison, one admin staff, and three complaints officers. Each complaint would be triaged and sent out to each divisional co-ordinator. The trust complaints policy was due for review in May 2018.

Each division identified an investigation officer to lead on each complaint. Each formal complaint was documented on the trust’s risk management database. Responses were checked by either a member of the divisional triumvirate (divisional director, divisional nurse or divisional manager) or by the divisional quality and safety advisor, before being returned to the complaints team for further quality review. The chief executive was responsible for signing off formal complaints unless delegated to the chief nurse.

Patient experience reports shared information with regards to lessons learnt from complaints. Weekly multi-disciplinary patient safety summits allowed patient experiences to be shared across the trust. Trends were reviewed.

Between April 2017 and February 2018 there were 134 reactivated complaints, down on 230 from the previous 12 months. The main themes identified were disagreement with the trusts response or that not all issues had been addressed. Also, the complainant would sometimes request a local resolution meeting. Learning from this had led to a review of the initial acknowledgement letter that was sent out, that now included an option for requesting such a meeting.

The outcome letter included details of any necessary action as a result of the complaint, including the name of the person who was accountable for following this up.

Between April 2017 and February 2018 11 complaints had been escalated to the Parliamentary Health Service Ombudsmen, although only one had been upheld whilst another two were in progress at the time of our inspection.

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.

Areas for improvement were discussed. This included moving the process away from paper forms to a solely electronic documentation, and ensuring that all divisions had a consistent approach to the process.

All trusts are expected to develop their practice in learning from unanticipated deaths following the NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’ which requires NHS trusts to produce and publish an updated policy on learning from death.

The trust had appointed a mortality lead to work with the medical director in developing their approach to this, with the aim to provide a tool to identifying learning from any preventable death. This was still in development at the time of our inspection.

The present process began with a questionnaire for doctors to rate avoidability of death. A mortality review group met to consider each death and a Structured Judgement Review methodology was used which utilised both quantitative and qualitative information. If concerns were identified, an incident would be declared and escalated. After approximately 2000 reviews, the trust had identified three potentially preventable deaths, and through this pathway had been able to identify further areas where individual care could be improved.

Practice for identifying learning from deaths was not at a stage where relatives were invited in to the review process. The medical director and mortality lead also spoke of challenges that needed
to be considered when further establishing this process. This included better engagement from medical staff and the recent financial situation that placed funding at risk.

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>Medicine (including older people’s care)</td>
</tr>
<tr>
<td>London Stroke Clinical Network</td>
<td>Medicine (including older people’s care)</td>
</tr>
<tr>
<td>Getting It Right First Time (GIRFT)</td>
<td>Medicine (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>End of Life Care</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Cancer &amp; Clinical Support Division</td>
</tr>
<tr>
<td>The most innovative department</td>
<td>Women and Child Health Division</td>
</tr>
<tr>
<td>Nomination for WellChild Award</td>
<td>Women and Child Health Division</td>
</tr>
<tr>
<td>TARN (Trauma Audit and Research Network)</td>
<td>Acute Division</td>
</tr>
<tr>
<td>QST (Quality Surveillance Team)</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>British Society of Uro-gynaecology (BSUG)</td>
<td>Specialist Medicine Division</td>
</tr>
<tr>
<td>British Society for Gynaecological Endoscopy (BSGE)</td>
<td>Specialist Medicine Division</td>
</tr>
<tr>
<td>British Society for Colposcopy and Cervical Pathology (BSCCP)</td>
<td>Women and Child Health Division</td>
</tr>
<tr>
<td>Baby Friendly Initiative (BFI) stage 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Getting it Right The First Time - Peer-review scheme</td>
<td>N/A</td>
</tr>
<tr>
<td>Chemotherapy Peer review</td>
<td>Cancer &amp; Clinical Support Division</td>
</tr>
<tr>
<td>BS EN ISO 9001:2015</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>HFEA Licence</td>
<td>Women and Child Health Division</td>
</tr>
</tbody>
</table>

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

The trust gained ISO 9001:2015 accreditation in January 2018. ISO 9001 is an international standard that specifies requirements for a quality management system (QMS). Organisations use the standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements. The assessment stated that the trusts’ management systems were clearly embedded within departments and audited and aligned with its needs and
strategic direction. A sample taken during the assessment, showed patients were provided with individual care.
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.
Urgent and emergency care at Queens Hospital included an emergency department, an enhanced urgent care centre, and a dedicated children's emergency department (children's ED). The emergency department treated people with serious and life threatening emergencies. Adults and children with less urgent illnesses and minor injuries were treated in the enhanced urgent care centre (EUCC). All services operate 24-hours a day, seven days a week. The hospital had one of the highest attendances in England, and numbers attending increased 3% over the previous 12 months. Between July 2016 and June 2017 there were 250,466 A&E attendances at Queens Hospital, of which on average 22% of patients were admitted. About 27% of attendances were children. The trust saw more than 170,000 patients with serious, life-threatening conditions a year.

Patients present to the department either by ambulance through a dedicated ambulance only entrance or by walking into the reception area.

The emergency department has different areas for treating patients depending on their needs. A resuscitation area has eight bays (two designated for use with children and one with equipment for trauma patients). This area has full facilities for resuscitating critically unwell patients, for example a patient with a serious injury or heart attack. The majors’ area has 26 bays including a room for patients needing isolation.

There is a dedicated room suitable for the assessment of people with acute mental health issues. A separate paediatric ED has its own children’s waiting area and 10 bays.

The EUCC has nine consultation rooms, two procedure rooms, a plastering room and a chaired treatment area.

The department was previously inspected in March 2017 and was rated as requires improvement in all domains.

We inspected the ED over three consecutive days in January 2018 and again in the afternoon and evening of 8 February 2018. We looked at 22 sets of patient records. We spoke with over 50 members of staff including doctors, nurses, managers, allied health professionals, support staff and ambulance crews. We spoke with 22 patients and 8 relatives who were in the department at the time of the inspection. We reviewed and used information provided by the trust in making our decisions about the service.

The CQC inspection took place during high winter pressures across the country. This was a time of extreme pressure on all emergency departments.
Total number of urgent and emergency care attendances at Barking, Havering and Redbridge University Hospitals NHS Trust compared to all acute trusts in England.

(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission
The percentage of A&E attendances at this trust that resulted in an admission increased between 2015/16 to 2016/17. In 2016/17, rates were similar to the England average.
(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>50,041</td>
</tr>
<tr>
<td>Discharged*</td>
<td>155,950</td>
</tr>
<tr>
<td>Referred*</td>
<td>18,190</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>2,864</td>
</tr>
<tr>
<td>Died in department</td>
<td>256</td>
</tr>
<tr>
<td>Left department#</td>
<td>13,211</td>
</tr>
<tr>
<td>Other</td>
<td>10,216</td>
</tr>
</tbody>
</table>

* Admitted to hospital 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 trust set a standard of 90% for completion of mandatory training. The trust monitored compliance through an electronic training recording system. A breakdown of compliance for mandatory courses from April to October 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>83</td>
<td>107</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>82</td>
<td>107</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>80</td>
<td>107</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff did not meet the training standard during that period for any of the applicable courses at. Only 66% of medical staff had completed the ‘Health, Safety and Welfare’ course at that time. On inspection the divisional governance meeting notes indicated that compliance with mandatory training had improved, although the data we saw was not directly comparable with the PIR information. The trust had made 28 mandatory training modules available to locums to help ensure all ED locums were up to date with mandatory training.

At the last inspection the lack of assurance that locum doctors had resuscitation training had been a concern and CQC had required an improvement in performance. Senior leaders had assured training standards by requiring any locum who joined the department to have their CV approved by a substantive member of the consultant body. Locums were required to have advanced life support (ALS) or advanced trauma life support (ATLS) and paediatric life support (PLS) to work in the department. They should also be a Member of the College of Emergency Medicine (MCEM) or Fellowship of the Royal College of Emergency Medicine (FRCEM), which is achieved through examinations taken by specialists in emergency medicine. The improvement required had been achieved and we saw evidence of a continuing process to maintain this.

The trust ran ATLS courses once a year for 20 staff, mainly doctors. Four nurses attended in each of 2016 and 2017.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Moving and Handling Level 1</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>350</td>
<td>355</td>
<td>99%</td>
<td>Infection Prevention and Control - Aseptic</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff met the training standard for all applicable courses.

National standards for children and young people in emergency care settings state that there must be a nurse with advanced paediatric life support (APLS) qualification on each shift. On the last inspection we found that 35% of shifts within the prior three months had not met this standard. The nurse in charge we spoke to on one day of this inspection did not have APLS. The trust confirmed after the inspection that all paediatric nurses in ED had completed paediatric intermediate life support (PILS) training. There was not a nurse with advanced paediatric life support training on shift during our inspection, but medical staff had advanced life support training. All Paediatric band 5 and 6 nurses were being funded for European Advanced Life Support training (EPALS) so all would be trained to this level by the end of 2018.

Records confirmed that band 5 nurses and 95% of band 6 nurses had had intermediate life support (ILS) training. We saw there were monthly training dates and all would have Advanced Life Support (ALS) training by May 2018. This followed a significant training effort in this area in 2017.

At the last inspection we found that locum doctors did not have training in sepsis management, although educational work was taking place on recognising, escalating and acting upon the signs of a potential sepsis infection. On this inspection we found sepsis management training was available to ED locum doctors. Staff were expected to complete mandatory sepsis e-learning (yearly) supported by a once only mandatory face to face training session. Training rates were 87% for all ED staff in December 2017.
Safeguarding

There were processes, practices and systems to keep people safe from abuse.

Staff we spoke with understood their responsibilities in relation to safeguarding vulnerable adults and children and were able to define triggers that would prompt them to obtain a safeguarding assessment for patients. They knew where to find safeguarding information, including contact numbers of lead staff.

When child patients presented to the Enhanced Urgent Care Centre (EUCC) the computer screen flagged children known to be at risk and previous attendances. Staff printed off information for any child streamed to the GP (as the GPs’ used a different IT system) and attached the report to the child’s notes. Each day staff reviewed all the previous day’s child attendances as a failsafe to ensure no safeguarding concerns had been missed. Nurses considered safeguarding a strength for the division.

However, we noted from records that doctors did not always complete the seven questions at the end of the children’s triage form relating to safeguarding status, or state they did not apply. It would be good practice to complete this.

The safeguarding governance structure was updated in September 2017. The chief nurse was the executive lead for safeguarding, representing the trust at local safeguarding children and adult boards. The deputy chief nurse managed the safeguarding team. Named professionals within the team represented the trust at safeguarding sub groups. Safeguarding reports were shared at the trust's Quality Governance Steering Group and the Quality Assurance Committee (a sub-group of the trust board). In addition, Safeguarding Adults and Children Progress Reports were shared with the commissioners at Clinical Quality Review meetings. Safeguarding Children & Adult Annual Reports were presented to the trust board.

The trust set a standard of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 4</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>85</td>
<td>106</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>68</td>
<td>107</td>
<td>64%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At that date the trust did not meet the standard for doctor’s compliance for two of the three applicable courses, scoring only 64% for the ‘Safeguarding Children Level Two’ course. However, we found on inspection that 84% of medical staff had completed level 3 Safeguarding for children by December 2017 which was an improvement, although the issue remained on the risk register.
A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Standard (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>291</td>
<td>298</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>184</td>
<td>194</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>149</td>
<td>161</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met their standard for nursing staff for all four applicable courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We saw evidence of safeguarding reporting, for example after a patient under the age of 16 had presented themselves at the paediatric emergency department (ED) following an incident of self-harm, and we saw an adult safeguarding report from an ED nurse.

**Cleanliness, infection control and hygiene**

The hospital had established systems in place for infection prevention and control, which were accessible to all staff. The systems were based on the Department of Health’s code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of the spillage of body fluids.

The whole ED area was tidy and well maintained. This was the case during our inspection even though the department was exceptionally busy. We reviewed all patient areas as well as clean and dirty utility areas and treatment rooms. All areas were visibly clean. Patients and relatives were satisfied with the level of cleanliness.

We saw domestic staff cleaning the department throughout the day. The domestic staff we spoke to understood their cleaning routine and also responded quickly to unexpected cleaning needs. Cleaning audits were undertaken to monitor cleanliness, although neither these nor cleaning schedules were on display except in majors cubicles, where a cleaning checklist prompted staff to clean the bay appropriately between patients.

Clinical staff cleaned clinical items, using stickers to denote equipment that was clean and ready for use. However, we noticed several scales in majors with stickers on them, which had obvious sticky tape residues which could harbour bacteria and be an infection risk.

Staff had easy access to personal protective equipment (PPE) such as aprons and gloves in all areas and we saw staff used PPE as required during our inspection. However an undated audit sent to us after the inspection showed 67% usage of PPE in majors and 83% usage in resus. There was sufficient access to handwashing and drying facilities. However, some of the hand sanitising dispensers were empty.
Hand sanitising dispensers for the public were not always well-placed. For example, there was no dispenser at the entry to the EUCC or at the exit from there to ED. The only sanitisers in the waiting room were on the back wall. We saw few people use these as they were difficult to access when the waiting room was full. However, staff said that if hand sanitisers were placed at the entrance there was a risk that patients might misuse the cleaning substance which contained alcohol. In majors, dispensers were not in every cubicle, they were on beds not trolleys.

At the last inspection we had found not all staff regularly cleaned their hands as they moved from one area to another or when leaving or entering departments. There was now a hand hygiene strategy in place. Audit showed significant improvements had been made since the first quarter of 2017, notably in adult ED where results in January 2017 had been low, at 50%. Staff told us there were hand hygiene champions to provide leadership and maintain hand hygiene standards. Staff were ‘bare below the elbow’ which enabled them to wash their hands and forearms effectively. We observed good hand hygiene on inspection although managers told us there were still some challenges and spot checks and monthly audits were carried out. Failure to comply with hand hygiene requirements, putting patients and staff at risk of infection, was a moderate risk on the ED risk register. We reviewed hand hygiene data for the paediatric emergency department where results average 98% in the last three months of 2017 and the adult emergency department where the results averaged 93% over that period.

At the last inspection we had observed inconsistencies in the storage of hazardous waste and had required improvement in this. On this inspection we saw many staff had completed waste management training. We did not identify any issues with disposal of contaminated and hazardous waste. Arrangements were in line with national standards.

Where adult patients attended ED with a known or suspected infection they were cared for in a specific single room in majors. There were two rooms in paediatric ED for children suspected of being infectious. However, some staff in the EUCC were less sure how to manage attendance of someone potentially infectious. For example, we saw a member of staff advise a pregnant woman that there was a child with hand-foot-and-mouth disease (HFMD) in the area, but there no alternative place for the adult patient to wait. We also saw a patient who had told staff they were undergoing chemotherapy, but who was asked to wait in the crowded waiting room, despite their compromised immunity, on the grounds they were attending because of a minor injury.

**Environment and equipment**

The trust acknowledged that the overall urgent and emergency care capacity at Queen’s was not fit for current or future demands. There was a lack of space to examine patients, lack of space in the medical assessment unit (MAU) to support those needing longer observation and insufficient inpatient beds in the hospital, particularly in winter, which led to treatment delays. There was a five year plan to improve this.

Since the last inspection the urgent care centre had moved. It was now called an Enhanced Urgent Care Centre (EUCC) and offered a wider range of services in one place, including access to blood tests and X-rays. The EUCC was geographically slightly further from the rest of the emergency department. The new (interim) reception and joint waiting area for ambulatory patients presenting to urgent and emergency care was the first part of a longer term refurbishment plan. It had only opened two weeks before the inspection and staff were still adjusting to the new arrangements and making some changes in the light of experience.
We had a number of concerns about the reception and waiting area, which clinical staff also shared. The lack of manoeuvrability in the cramped waiting space, security of staff and patients, noise and high temperature. Children and adults waited in the same space, although the trust partly resolved this concern during the inspection by arranging another waiting area for children streamed to see the GP. The area was not fully accessible to those with limited mobility.

The logistics of moving seriously ill ambulatory patients rapidly from EUCC to resuscitation or majors had not been fully worked out at the time of the inspection, and was a safety risk. Although there had been no serious incidents in relation to delayed care on transfer to ED, staff told us of three incidents where they had felt concern about the transfer of patients. A number of clinicians shared their concern about this with inspectors. In the event of patient collapse when the waiting area was full, access for staff and equipment was difficult. Although senior staff told us that it was possible to move a trolley into the waiting area, other staff said that in practice they had to take patients to ED in a wheelchair. We observed a patient being transferred to a wheelchair in the waiting room. There was not enough room to take the wheelchair to the person’s seat and they had to be assisted to walk towards the chair.

The patient waiting area had 45 fixed seats as well as additional loose chairs. Patients for whom there were no seats were sitting on the floor or standing. There were 68 patients in the waiting room at 3pm on the second day of our inspection. Seating had been planned assuming a maximum 15 minute wait for streaming and an overall average time in EUCC of 120 minutes. Operational performance at the time of the inspection did not deliver this target with consequential pressure on the waiting space.

Staff told us the atmosphere in the waiting room became tense if a patient became agitated or distressed. We observed this. Although there was CCTV in the waiting room and regular security guard patrols throughout the area, reception staff felt vulnerable as they did not have full visibility of the waiting area and could not observe who was coming in. A clinician visually checked the waiting area every 15 minutes (logging this check in a book) with the intention that staff could intervene if a patient’s condition rapidly deteriorated, or a situation developed. Frontline staff did not think this sufficient to ensure safety.

A further staff safety issue was that the complex streaming (assessment/ triage) rooms did not have two exits because space was not available. Two exits would enable staff to escape if a patient became violent. There was a panic button in each room, but not all staff were aware of this. Staff felt vulnerable when treating patients in a closed room so they did not close the door when assessing a patient. This was safer for the staff, but limited patient privacy and confidentiality as the rooms were opposite the simple streaming pods. The trust told us after the inspection that access and egress were key to planned changes to ED reception. The plans were still at design stage.

People registering at reception had to speak loudly through glass panels for staff to hear them. We also saw patients try to put their heads and hands through the spaces between the glass panels which was a risk to staff. The streaming staff had to shout out people’s names to call them for streaming, in order to be heard above the noise of a full waiting room. There was no intercom.

The waiting room and the receptionist’s room were very warm. The air conditioning did not work and the receptionists were using a fan to help cool their room, despite it being winter. The room was very small for four people and their computers. The staff had one telephone between them. Senior staff explained that hospital temperatures were centrally regulated and estates staff were working on better cooling of the space. There had been no improvement in the temperature when we returned two weeks after the initial inspection.
Children and adults shared the same waiting area at start of our inspection in January 2017. This shared space did not meet the recommendation for a separate entrance and reception for the children’s area (Health Building Note 23 – ‘Hospital accommodation for children and young people’). During our inspection, to improve safety for children and babies, the trust converted a consulting room to a paediatric waiting area, where adults attending with children could wait to see a GP after streaming. This partly complied with the DH building note which says that waiting areas for children should not allow patients or visitors within the adult area to view the children waiting. However, those with children nonetheless waited in the waiting room until they had been streamed, which could be over half an hour. The trust told us after the inspection that the future expansion of the reception and waiting zone would allow this to be improved.

We were told the waiting area had been designed on near peak (95%) throughput of 26 patients an hour and was compliant with Health Building Note 15-01. However, the patient throughput was higher than this at peak times, for example, staff told us 177 people registered between 9am and 2pm on Monday 29 January 2018. The number of patients (293) who were treated in the QH EUCC that day was above the January average (276). The total number of EUCC patients that day was considerably over the 240/day average used for planning. However, the number of people in the waiting area appeared similar on the other days of the inspection, and also when we returned unannounced 10 days later.

Patients returned to the waiting room after diagnostic tests such as X-ray or blood tests, adding to the pressure on seating. The planning assumptions assumed EUCC patients would be treated in 45 minutes which was not the case. Waits for pathology results were at least an hour. We recognise that the CQC inspection took place during high winter pressures across the country. There were problems with flow through ED generally at the time of the inspection both because of the level of demand, and specific operational problems in the newly opened EUCC. The trust subsequently told us they had developed an action plan to deal with these issues.

Toilets were available for patients attending the service, including accessible facilities with baby changing equipment available to either sex. There was no separate infant feeding facility. There was free drinking water (although we noted that there were no cups at intervals during the day). There was no vending machine in the waiting area. During the day patients had access to cafes in the hospital foyer and at night there was 24/7 vending available in the hospital’s main atrium.

Senior managers told us that a larger waiting area was planned, subject to planning permission, but the current space would be in use for at least nine months. After the inspection the trust told us that one stream of ED patients would move in late May. It was anticipated this would alleviate overcrowding.

The clinical areas behind the waiting room provided sufficient space for treatment. There were eight consultation rooms, two procedure rooms, a plastering room and a chaired treatment area and service areas. However, parts of the EUCC were not wheelchair accessible

The main ED had a separate entrance for ambulances in line with national guidance. The area for triage had five assessment bays which were not sufficient for the numbers arriving by ambulance at this time of year. On each occasion we visited this area there were eight or more patients awaiting triage, with the queue sometimes extending outside into the corridor. We acknowledge that the inspection took place during high winter pressures throughout the country, and that the full capacity protocol was in operation.

The increased number of waiting patients resulted from the use of the full capacity protocol. The trust had introduced a Fit to Sit model in the RAFTing area, and cohorting of patients to enable
quicker releases of ambulance crews. A cubicle in the Majors area, adjacent to RAFTing was used to assess suitable patients and transfer them back to chairs following the assessment.

On 8 February a number of ambulance crews were waiting for trolleys to which they could transfer patients and one had been there over four hours.

The move of the EUCC had included the opening of a larger ambulatory care area, which staff had welcomed as it enabled them to see more patients referred from ED for same day treatment and discharge.

A separate paediatric emergency department had good facilities. Access was secure, and the area had child-friendly wall decorations, facilities for nappy change, and entertainment for children. There were two private rooms for children who were infectious or for a child with mental health needs. The rooms were not specifically designed to minimise the risks presented by patients with mental health needs. If a patient presented a heightened risk, the service placed them in the mental health room within the main ED. There was a medium term plan to co-locate a paediatric assessment unit with the paediatric ED by summer 2018.

The emergency department’s resuscitation area had eight bays, two of which contained equipment suitable for resuscitating acutely unwell children. One bay was additionally equipped for trauma patients. The hospital was a major trauma centre for isolated head injuries, and a trauma unit for all other major trauma. It was part of the North East London and Essex Trauma Network (NELETN).

The ED had a 26 bay majors’ area to accommodate seriously unwell patients who needed to stay in the department for monitoring, assessment or investigation.

Staff told us they had the equipment required to care for patients and had sufficient access to computer terminals to allow access to pathology and imaging results as well to review policies and guidelines.

We checked various pieces of equipment throughout our inspection including electrocardiogram (ECG) and weighing scales and saw they had all been safety checked. Equipment had stickers indicating calibration checks where relevant.

We observed spare consumables were appropriately stored and labelled. We checked various consumables, such as fluids, and found all of them were in date.

Resuscitation trolleys were available at several locations throughout the urgent and emergency department. Trolleys were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. The trolleys were clean and checked daily with staff signing to confirm they had checked the trolleys.

The service had designated a room specifically for the assessment and care of patients with mental health needs. The layout of this room was compliant with national standards. The room had two doors, a viewing panel, sturdy furniture, seating for up to four people, security cameras, an alarm button and anti-ligature fittings. The room did not have designated toilet facilities. The service could provide a mattress for this room when patients stayed overnight. This room could not be seen directly from the nursing station. If a patient using the room presented a risk, nurses would inform security and ask them to stay close to this room. Another side room was also available for patients with mental health needs if the service needed additional private space. Staff could remove all equipment from this room and provide a mattress. This room was located opposite the main nursing station to allow staff to observe the patient.
Within the EUCC, staff told us they would arrange for patients with mental health presentations to await assessment and treatment in an area opposite the reception desk, so staff could observe them.

The diagnostics and screening department for the hospital was co-located with the emergency department, and there were X-ray, MRI and CT scanning facilities within that service.

### Assessing and responding to patient risk

Patients presented to the department either by walking into the reception area or arrived by ambulance through a dedicated ambulance-only entrance.

Reception staff did not use the first contact protocol to ensure high risk patients were seen more quickly or to wave through patients who met the criteria for automatic direction to ED. Every patient awaited a brief clinical assessment to assess the patient’s acuity and priority before navigation to the most appropriate service. This meant some patients, for example young babies and patients on chemotherapy treatment, had avoidable delays to treatment.

The streaming process was in line with NHS Improvement good practice guide on improving patient flow (2017); however, records and our observation showed that simple streaming by a nurse or GP to decide the most appropriate area for the patient to be treated was not being achieved within the 15 minutes recommended in RCEM guidance. This was sometimes taking over an hour during January 2018, whilst the GP streaming protocol was bedding in. Simple streaming involved taking a brief history and performing basic observations, if necessary, including calculation of early warning scores.

Ambulances took patients to a separate ED entrance where those requiring immediate treatment were taken directly to the resuscitation area. 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. This enabled staff to prioritise care and treatment for patients with the most urgent needs.

Other patients arriving by ambulance were triaged in the rapid assessment and first treatment area (RAFT). During the day doctors worked in this area, to provide early senior assessment of patients. They used a standard template. The funded establishment allowed for two or three doctors to carry out the ‘RAFTing’ process but staff told us there was often only one doctor assigned to the area. Patients received initial treatment in the RAFT area and were then allocated to a treatment bay, if one was available. Staff used an ED safety checklist as part of the assessment process which detailed hourly activities, up to 12 hours from admission. At night, a nurse triaged patients arriving by ambulance.

The rapid assessment also sought to identify patients who were ‘fit to sit’, in line with national recommendations.

We saw staff completed risk assessments for patients, such as risk of falls. Allergies were documented in all the notes we saw.

Patients were assessed for venous thromboembolism (VTE) and those at risk of VTE were offered appropriate prophylaxis in accordance with NICE guidance. VTE is a condition where a blood clot forms in the vein. However, two patients whose records we reviewed and indicated possible DVT did not have a Wells clinical prediction score to estimate the risk level, which is a guide to subsequent investigation.
Skin vulnerability assessments were completed for frail and elderly patients. We looked at patient records and saw that the process was in line with RCEM guidance. A number of community acquired pressure sores were identified.

We saw that staff were using a delirium screening tool or a capacity tool for people with dementia. Where possible patients with dementia were moved out of ED to wards where closer monitoring was possible.

We noted that the ED patient record tracker did not record NEWS scores so nurses had to provide these during the multidisciplinary handover in ED when the medical and nursing team reviewed each patient’s status.

Children who attended by ambulance, unless needing resuscitation, were directed to the children’s ED where a paediatric nurse undertook triage.

There were standard pathways in line with national guidance for diagnosis and treatment of conditions such as head injury, or patients with cardiac arrest, abdominal pain, and diabetic emergencies which enabled treatment to start promptly. There were guidelines for the management of sudden infant and child death. There was an ambulatory care pathway to treat suitable unwell patients and send them home to return for a review of ongoing management at ‘hot clinics’. Other patients, particularly those needing additional support at home were referred to the clinical observation unit where they might stay overnight. The ED referred patients who might need admission to either the Elderly Receiving Unit or the Medical Receiving Unit for stabilisation and treatment until they were transferred to the ward treating the patient’s specific speciality, or in the case of elderly patients, to the acute elderly wards.

The service did not use any specific tools or rating scales for triaging patients with mental health issues, and did not use the rating scale for self-harm that is recommended in national guidance. However, when staff triaged a patient with mental health needs they assigned them a high priority rating and informed the nurse in charge.

Staff did not keep specific records on the use of enhanced observations of patients presenting a heightened level of risk. However, staff gave an assurance that only nurses or healthcare assistants carried out enhanced observations. The service did not assign security staff or registered mental health nurses to specific observations of individual patients.

If a patient left the unit before treatment and referrals were complete, and the patient presented a risk of harm to themselves or other people, staff would contact the police. Within the urgent care centre, staff made notes of patients’ physical appearance and clothing to assist in finding patients who left the unit.

<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 emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<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>
</tbody>
</table>
Q33. In your opinion, how clean was the emergency department?

8.2 About the same as other trusts

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

9.3 About the same as other trusts

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard at all during the 12 month period from November 2016 to October 2017, with average times of more than 80 minutes each month over the year.

**Ambulance – Time to treatment from November 2016 to October 2017 at Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing ambulance time to treatment](image)

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

At the last inspection we had concerns patients were not being assessed within recommended times and sometimes experiencing lengthy delays before being seen. We made a requirement for the trust to ensure a clinician saw all patients in a timely manner. The trust had made some improvement since the last inspection and was continuing to work on this. However, we reviewed information provided by the trust and observed admissions by ambulance and saw that assessment did not always take place within the standard time.

The pressures from ambulance conveyed patients were very high. The trust had patients from both London Ambulance (LAS) and East of England Ambulance (EoEA) and the trust had the highest volumes per day in London. The CCG was reviewing ambulance conveyance review with the two ambulance trusts to see how management could be improved.

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Queen’s**

![Graph showing ambulance turnaround times](image)
Hospital

![Graph showing percentage of patients waiting 0-15 minutes, 16-30 minutes, and over 30 minutes from Dec-16 to Nov-17.](Image)

(Source: National Ambulance Information Group)

We spoke with four paramedics who said turnaround times were average by comparison with other hospitals at this time of year. They told us there was often a wait of 25-35 minutes to handover. During our inspection we saw that about 60% of turnaround times were 30 minutes which was an improvement on performance earlier in the year. January 2018 the ambulance turnaround dropped to about 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 October 2016 to May 2017 the trust reported 39 “black breaches”, with no trend over the period. Black breaches were particularly high at Queen’s Hospital on 3rd January 2017. The reason given for these breaches was that waiting time remained at five hours due to excessive volume, due to an in internal incident. During our unannounced inspection on 8 February there were some black breaches because of the high volume of patients coming by ambulance that day.

![Graph showing number of black breaches from Oct 2016 to May 2017.](Image)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

Identifying and treating sepsis was a focus of the emergency department. At the last inspection we found educational work taking place around early identification of sepsis and sepsis pathways. This followed a CQC requirement to improve response times to suspected sepsis. On this
inspection we found good awareness of sepsis. A sepsis screening tool and a sepsis 6 pathway were available in all clinical areas. Sepsis trolleys in ED ensured staff had immediate access to sepsis equipment if required. However, there was no sepsis trolley in the EUCC. Managers told us there was a drawer with sepsis medication in the EUCC, but some staff were not aware of this. After the inspection, the trust told us patients requiring this level of treatment would be streamed and treated in the main ED.

On inspection we saw that fortnightly sepsis audits were carried out with immediate feedback to staff teams on compliance, performance and areas for improvement. Results were discussed formally at the monthly ED Quality & Safety Governance Meeting. Audits showed good compliance with sepsis screening 98-100%, and with administering antibiotics within an hour; however, performance against other treatment measures was inconsistent although above the national average, except for urine output within an hour. NHS England had recently commended the trust for being one of the trusts which had seen the greatest improvements in performance in assessing and treating sepsis within its emergency departments. The trust was undertaking more work, in line with a national CQINN, which stands for Commissioning for quality and innovation. The system makes a proportion of healthcare providers’ income conditional on demonstrating improvements in specified areas of patient care.

The hospital used the National Early Warning Scoring System (NEWS) and the modified versions for children and babies. The result of the most recent early warning scores audit was 100%. We reviewed 22 sets of patient records at this site during the inspection and saw early warning scores had been completed and correctly calculated, for all patients.

At the last inspection we found fire safety awareness was low, and we set a requirement for ensuring fire doors were not propped open. On this inspection we found a high proportion of staff had fire safety training. We did not see any fire doors forced to remain open as we had on the previous inspection. Staff told us there was a plan to train fire marshals in each area.

The trust participated in the Emergency Department Survey 2016 and scored “about the same” as other trusts for all questions in the Emergency Department Survey 2016 in relation to the safe domain.

Nurse staffing

The Department had longstanding challenges in recruiting permanent ED staff.

The trust reported their registered nursing staff numbers as below from 30 September 2016 to 30 September 2017. Information provided by the trust was not broken down to individual hospital site, but we found on inspection that many staff worked across sites.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>223.30</td>
<td>158.29</td>
<td>71%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers- Planned vs actual)

There were two matrons in ED, one with a specific interest in paediatrics and resuscitation and the other covering ambulance assessment and triage. Responsibility for majors was shared.

Nursing allocations were planned at the beginning of each shift and covered the whole of ED including the EUCC. Staff were allocated according to activity levels in the different areas and flexed during the day as needed. Staffing establishment and actual staffing was not displayed in
any part of ED. We observed one nurse handover during the inspection. All nurses attended for the allocation session and key information or announcements were made. There was no overview information given about the current level of activity. A more detailed handover then took place as each nurse took a ‘bedside’ handover of patients in the areas they were allocated from the outgoing nurses.

There were four streaming clinicians in the EUCC, either GPs or nurse practitioners. There were no paediatric nurses in the EUCC and only one GP saw children. This potentially caused delays in assessing children. The establishment included four nurses and two support workers for phlebotomy and plastering. Other staff were accident department assistants (ADAs), emergency nurse practitioners (ENPs, Band 7) and an advanced nurse practitioner (ANP).

Triage was by a paediatric nurse or a paediatric triage trained adult nurse. Some staff in paediatric ED worked short, twilight shifts. The nurse in charge told us the team were reluctant to use agency staff which meant said they were short of staff when nurses were ill. On this inspection, we found the nurses working in the paediatric ED were paediatric trained, including at night, although the number of paediatric trained nurses was still a red rated risk on the risk register. Staff told us there was not always a band six nurse on shift but the department complied with the Royal College of Paediatrics and Child Health (RCPCH) guidelines to have two trained children’s nurses on duty 24 hours, seven days a week. However, we were assured that one nurse was qualified in PILS on each shift. In addition, there was always a paediatrician with APLS as this was a requirement for working in ED at the trust. All Paediatric band 5 and 6 nurses were being funded for European Advanced Life Support training (EPALS), so all would be trained to this level by the end of 2018.

A new safer staffing tool was being introduced with an associated traffic light rating for red, amber and green as a visual clue to the safety of the staffing level. All nursing sisters were to receive training on the new tool.

At the last inspection there had been a high nurse vacancy rate of 50% in ED. At this inspection we found there were still vacancies although at different bands. There were 38 band 5 vacancies at January 2018, but only one Band 6 vacancy. Vacancies were covered where possible, by bank/agency staff. The trust had a rolling recruitment programme and interviews were taking place during our inspection. The vacancy rate had reduced to 30%. We noted that most vacancies were filled with bank staff.

In mid-February 2018, 15 new healthcare support workers were starting work. They would complete training in their core competencies before they could work in ED.

The shortage of adequate paediatric nursing capacity was rated as high on the December 2017 corporate risk register as a risk to patient care. Documentation showed this was a long running problem.

From October 2016 to September 2017, the trust reported a turnover rate of 1.3% among ED nursing staff. This rate met the trust’s standard of 13%. The overall turnover rate for nursing staff across all core services was 1.4%. At Queens the reported rate was 1.6%, which is very low. However, staff told us turnover was higher than this and other documentation indicated turnover of up to 26%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The department carried out exit interviews. Of the 26 leavers between August 2017 and January 2018 nine were medical staff and 13 were nurses. Six doctors were on fixed term contracts. Eight staff were relocating, five cited work life balance and others had dependents. 10 of the nurses
were band 5. We learned that action was being taken to give more support to band 5 staff to encourage retention.

From October 2016 to September 2017, the Queens hospital reported a sickness rate of 5% in urgent and emergency care for nursing staff. This did not meet the trust’s target of 2.8%.

We saw from the notes of the sisters’ meeting that sickness was discussed. There was no long term sickness. There was some indication that some staff were taking more sick leave in pregnancy and managers had issued a reminder to staff about the rules, as well as coaching on sickness management for new managers.

From October 2016 to September 2017, the trust reported that there were bank and agency staff on 49% of shifts within urgent and emergency care were covered by bank and agency staff. Breakdowns by site were not provided by the trust.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

On inspection we found a high use of bank and agency staff, and minutes of meetings indicated that not all vacancies were covered on all shifts. However, staff told us there were many regular agency who were part of the team. Regular agency nurses were supported to attend training. We were told most healthcare assistants were bank.

Bank and agency staff were used to maintain numbers and skill mix of nursing staff in the department. During the inspection we found some shortfalls in staffing numbers from short term staff sickness. RCN guidance recommend two registered nurses to one patient in cases of major trauma or cardiac arrest, and one registered nurse to four cubicles in major or minor trauma. This was in line with the establishment figure for the trust but was not achieved during our inspection. Staff told us the ratio was often 1:6 in majors rather than the recommended level of 1:4. No clinical incidents had been raised regarding bank and agency levels linked to patient harm.

Medical staffing

The trust reported their registered medical staff numbers as below from 30 September 2016 to 30 September 2017. Information provided by the trust was not broken down to individual hospital site, but most doctors worked on rotation at both emergency department sites.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>79.88</td>
<td>47.50</td>
<td>59%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The Department had longstanding challenges in recruiting permanent ED medical staff. At the last inspection there had been a 40.6% vacancy rate amongst medical staff, but this had improved to a vacancy rate of 31%.

At the last inspection we had found high rates of consultant vacancies, 46%. At this inspection, the proportion of permanent consultants was now 61%. Locums covered the shortfall in substantive staff numbers. (Locum medical staff are fully qualified doctors but they do not always have the
specialist skills required for treating patients in emergency situations). We were told most locums were long term.

On this inspection we found the trust still rated the level of medical staffing high risk. On one day of the inspection there were seven clinicians working in majors rather than the establishment of 10 doctors.

At the last inspection we found a high number of vacancies for middle grade doctors. There continued to be gaps at this grade, covered by locums. However, recognising that some staff preferred locum work they offered training opportunities and long term locums were allocated an educational supervisor with opportunities for a rotation through emergency medicine, paediatric emergency medicine, acute medicine and anaesthetics. This had increased recruitment and retention.

Queen’s ED had an almost full establishment of trainee doctors, with an extra allocation of a higher ST4 doctor this year and an extra FY2 since August 2017. There were only two gaps. Previous concerns about junior doctor training appeared to have improved.

A range of activities were underway to improve recruitment and make medical posts more attractive. Managers had improved the in-house bank rates to compete better with agencies. They reported having interest in bank posts from staff in the trust, including from doctors in ITU and medicine. However there were challenges; the national shortage of ED doctors; the intensity of the workload at the trust, the historical negative perception of the Trust’s Emergency department and the geographical location of the Trust with only outer London weighting.

Managers had run two recruitment workshops for consultants and juniors. Consideration was being given to incentives such as free accommodation for recruits from more than 150 miles away and child care out of which they had recruited 25 middle grade and SHO doctors. The trust were advertising for staff in South Africa and India.

From October 2016 to September 2017, the trust reported a turnover rate of 4.4% in urgent and emergency care within medical staff, compared to an overall turnover rate for medical staff for all core services of 1.2%. This rate met the trust’s standard of 13%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2016 to September 2017, the trust reported a sickness rate of 2% in urgent and emergency care for medical staff. This met the trust’s target of 2.8%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust reported that bank or locum colleagues were involved in 84.3% of shifts within urgent and emergency care between October 2016 and September 2017.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In August 2017, 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 average for England.

Staffing skill mix for the 44 whole time equivalent staff working in Urgent and Emergency Care at Barking, Havering and Redbridge University Hospitals NHS Trust:

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>18%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>14%</td>
<td>35%</td>
</tr>
</tbody>
</table>
The emergency department had consultant cover between 8am and midnight. This ensured the department met the RCEM standard around consultant presence. The RCEM states that there should be a consultant present for a minimum of 16 hours a day. The department had recently introduced consultants who worked during the night, which meant on three to five days a week there was 24 hour consultant presence. We were told that on days with no overnight consultant, the non-resident consultant would often attend the department due to service need. In the day time the trust aimed to have a consultant in each area of the EUCC, RAFT (triage), paediatric ED, majors and the resus ward.

Managers told us the skill mix was under review. Currently they used RCEM guidance for the number of doctors based on patient numbers. They were training advanced clinical practitioners who would work on the doctors’ rota according to their associate skill level. Over time, this would help mitigate the shortage of doctors. They hoped later to introduce Consultant Advanced Clinical Practitioners.

The department had strengthened the GP and ANP/ACP staffing of the new EUCC. Staffing was one consultant, one registrar, two SHOs and two GPs. Staff said there was not always consultant at weekends.

The paediatric emergency department had a paediatric emergency medicine trained consultant available during the day. At night a paediatric doctor from the children and young people wards was on-call.

We attended a multidisciplinary morning handover in majors which was conducted efficiently and effectively. Reviews of patients later in the day were seen to be paper reviews rather than bedside reviews.

**Records**

Records were a combination of computer records, using more than one computer system, and paper treatment records. Some of the IT systems did not share interoperability so, for example, the electronic system for early warning scores could not feed into the ED patient record system. GPs in the EUCC used a different computer system to the main emergency department.

The main emergency department patient record system showed the patients name and the time of each event during the patient’s pathway through the department. For example, the time of arrival, the time of triage, the time of medical tests and the time of discharge. The paper treatment record of the patients’ care included details of any blood test results, electro-cardiogram results and a record of medicines that staff administered. Imaging results were on the computer system.

Some clinicians expressed frustration with the combined paper and electronic system because not all records were accessible in the same place. Staff told us it took several months to scan in the information before records were filed. Records were kept on site for 30 days, but a doctor in EUCC told us records were sometimes missing. This was reported as an incident.

We looked at 14 sets of adult records which were adequately completed.
We reviewed eight sets of paediatric records. All were signed and dated, but there were various levels of completion. For example, in only 50% of cases had the clinician completed the mandatory safeguarding section, and in only five out of eight was there completion of the sepsis pathway assessment (or confirmation it did not apply).

**Medicines**

Medicines (included controlled drugs) were stored securely in locked rooms so they were accessible only to authorised staff. The trust had implemented an automated system to manage stock levels and help reorder medicines when supplies were low. An audit trail of staff accessing the cabinet was available.

Maximum and minimum temperatures of fridges used to store medicine were appropriately checked and recorded each day to ensure medicines were stored within the safe temperature range set by pharmaceutical manufactures. The trust had recently found that the central temperature monitoring system did not provide assurance about ambient temperatures in clean utility rooms where medicines were stored, so manual thermometers were being introduced to provide this assurance. There was a standard operating procedure for managing medicines that exceeded the appropriate storage temperatures.

We reviewed controlled drugs records and saw that daily checks were made to reconcile stock levels with records of usage.

Staff had access to some labelled medicines packs for frequently used medicines given to patients after treatment, so nurses could give out supplies labelled with appropriate instructions for patients to take home. This enabled patients to go home sooner without waiting for pharmacy.

Patient Group Directions (PGDs) are a written instruction for the supply and/or administration of named medicines to groups of patients by nurses, without individual prescriptions, in an identified clinical situation. We were told that the use of PGDs had been suspended in the EUCC over a year ago, because changes in the paperwork made it time consuming to complete in triage. A decision was therefore taken to stop using PGDs and all medicines were prescribed by a doctor. The trust had invested in sending nurses and pharmacists on prescribing courses to develop more independent prescribers. Once implemented, it was hoped that the prescribing workload of the doctors would be reduced. Staff told us they could set up IV antibiotics in EUCC then pass the patient on to outpatient parenteral antimicrobial therapy (OPAT) team to manage the delivery of intravenous (into the vein or IV) antibiotics to patients who were medically stable, within their own homes.

We saw a microbiologist checking medicines prescribed in the medical receiving unit and suggesting changes for optimum treatments to support better flow and discharge through ED from which many patients had come.

**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 December 2016 to November 2017, the trust reported no incidents in urgent and emergency care classified as never events. However during the inspection a Never event was reported after a guidewire was retained after the insertion of a naso-gastric tube. The trust took immediate appropriate action. However the incident was subsequently de-escalated to as Serious Incident
because the incident did not fulfil 4.4 on the Never Event Framework. A retained guidewire in a Naso-gastric tube does not have the potential to cause serious harm or death.

The majority of incidents were reported in the adult emergency department; second was the paediatric emergency department and the fewest incidents were reported in the urgent care centre. The trust’s incident reporting figures were above the national average and the trust held bi-yearly incident reporting weeks to encourage reporting amongst all staffing groups. Staff told us incident reporting was blame-free. Senior staff considered the reporting threshold was low, which encouraged reporting. We saw that staff were thanked for reporting incidents and received feedback. Learning points from incidents were shared through a range of methods including directly through email, in newsletters and at staff meetings.

Between 1 January 2017 and 31 December 2017 3264 incidents were reported in urgent and emergency care, of which 95% were low or no harm. Incidents in December 2017 and January 2018 showed a similar pattern.

In the paediatric ED there were 188 incidents reported during 2017, two of moderate harm, eleven near misses and the remainder (93%) low of no harm. Incidents in the children’s ED averaged 15 a month. There had been one near miss in the 11 months to November 2017 and the other incidents were low or no harm.

In the urgent care centre 74 incidents were reported during 2017, one moderate harm, two near misses and the remainder (96%) were low or no harm.

In 2017 there were 18 reportableserious incidents. A round table meeting was carried out for all incidents. A concern on the risk register was a shortage of appropriately trained staff to undertake effective, high quality root cause analyses. We attended a round table meeting which had all staff involved in the care of the patient and sufficient discussion of the issues with and proposals for action. Staff told us an external team supported the department with serious incident investigations.

Themes of incidents at the time of the inspection were tissue viability, clinical care, documentation and communications and transfer and discharge. Pressure ulcers were mainly community acquired.

A mortality assurance group oversaw mortality trust wide. Mortality and morbidity meetings were held monthly in ED to discuss serious incidents, unexpected deaths and morbidities to identify learning. These were led by the ED consultant lead for trauma. The minutes of the November 2017 meeting, reviewing 14 deaths, recorded presentation and learning from a single case, although the learning was detailed.

The department did not keep specific records relating to the restraint of violent and aggressive patients. This meant staff could not monitor restraint to ensure that staff restrained patients safely. Staff told us about one incident during which they had restrained a patient. The record for this patient did not include any specific reference to the type of restraint used or the names of staff involved in the restraint. Staff had not recorded the incident on the electronic incident record.

Staff did not keep specific records relating to the rapid tranquilisation of patients, so could not audit the use of rapid tranquilisation to ensure it was carried out safely. We reviewed records of one patient, aged under 16, who had received rapid tranquilisation after becoming violent and aggressive. There was limited evidence that staff had followed national guidance. Records showed that staff monitored the patient’s heart rate, respiration and blood pressure once, five minutes after they had administered the medicine. National guidance states that observations should be carried out at least once an hour for such patients. For a patient under 16, staff should
monitor the physical health and emotional impact continuously. Staff had not recorded the incident on the electronic incident record.

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2016 to November 2017. The table below lists the types of incident in each location.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>King George Hospital</th>
<th>Queen's Hospital</th>
<th>Trust wide</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Adverse media coverage or public concern about the organisation or the wider NHS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4</strong></td>
<td><strong>6</strong></td>
<td><strong>1</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

(Source: NHS Improvement - STEIS)

Serious incidents (SI) are those that require investigation. Data provided by the trust showed that 10 serious incident investigations in ED had breached their internal deadline. However they had not breached external deadlines and no fines had been imposed.

There was a weekly Patient Safety Summit where a clinical team presented a case where the department had identified significant learning for the organisation, usually a Serious Incident. These sessions offered staff the chance to reflect as a group upon the care provided, consider what they could learn from each other and lessons to improve the awareness of patient safety in other areas. These sessions were well attended by a variety of staffing groups and chaired carefully to ensure the focus was on improvement rather than blame.

The Quality and Safety section of the trust intranet had information on Duty of Candour, learning from incidents and learning from safeguarding cases which were accessible to all staff.

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 were very clear about their responsibilities in relation to DoC, even though duty of candour training was not mandatory. When an incident was graded as moderate or above a duty of candour ‘flag’ was generated in the incident reporting system.

The trust’s Duty of Candour standard operating procedure guided clinicians as to when the DoC regulation applied, the expected timescales, the staff member(s) responsible for the required actions. There were model letters to formally communicate with the patient and relatives as appropriate.

The trust aimed to close all incidents within 20 days. Matrons and clinical leads reviewed reported incidents daily.
The hospital had regular violent incidents and two security staff were always in the ED area. There was a zero tolerance policy to bullying abuse and violence.

**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 is intended to focus staff 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, two falls with harm and no new catheter urinary tract infections from November 2016 to November 2017 within urgent and emergency care. The falls occurred in February 2017 and March 2017.

---

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers](image)

**Total pressure ulcers**

- 0

**Total falls**

- 2

**Total CUTIs**

- 0

(Source: Safety thermometer - Safety Thermometer)

**Major incident awareness and training**

A major incident plan was available on the intranet, and associated action cards were accessible to relevant staff. This plan provided clinical guidance and support to staff on treating patients in the event of different kinds of emergency incident. A major incident cupboard stored emergency equipment, including decontamination equipment if needed.)
Since November 2017 the trust had called a major internal incident five times because of the volume of patients and lack of beds.

Is the service effective?

**Evidence-based care and treatment**

The Trust had an Evidence Based Practice Group (EBPG) responsible for ensuring that new (or new to the trust) procedures and clinical processes were evidence-based and in line with known best practice and current guidance.

The policies, care and treatment pathways, and clinical protocols we reviewed were based upon recognised guidance, including that of the National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). This was an improvement because at the last inspection we found a number of clinical guidelines on the trust intranet were out of date.

Staff, including locums, told us guidelines were easy to access. We reviewed a random selection of proformas for procedural sedation, myocardial infarction with ST-segment elevation (a type of heart attack) and Transient Ischaemic Attack (mini stroke) which were in line with national guidance. We also checked some children’s guidelines for CAHMS referral and anaphylaxis. These were up to date and clear. However, some copies of guidelines printed and held in folders were not the current versions.

Whereas at the last inspection we found agency staff could not access trust policies and guidelines, on this inspection we saw staff could use a generic login, and staff were able to show us how to do this to find protocols. Doctors told us the department informed staff of updates to guidelines. On inspection we found some staff did not know how to find mental health policies and protocols.

Staff had recently completed a baseline assessment tool (BAT) to check that the care pathways completed for patients who had presented with head injury followed evidence-based guidance for management and treatment. BAT is an Excel spreadsheet that hospitals can use to identify whether their practice is in line with NICE guidance, and to help them plan activity to meet the NICE recommendations. The audit demonstrated that the management of Head Injury patients in ED did not comply with NICE Guidelines in all aspects.

One concern had been the time delay in arranging computerised tomography (CT) scans due to delays in the triage process. In response, clinicians decided patients with head injury should be prioritised for CT scanning, and if the triage waiting time exceeded half an hour, this should be escalated. A head injury proforma was introduced including a list of indications for CT scanning. However, staff told us that despite the recommendation that reporting should be done automatically, this was still not happening. A senior clinician had to call the duty radiologist to request the report. A re-audit in November showed there continued to be delays sometimes because the scanner was in use and at other times because of portering delays. The audit recommended the process should be streamlined so all ED scans were reported on automatically.

Other BATs had been used to review anaphylaxis, violence and aggression and short term management in mental health. Compliance with NICE guidelines had fallen in November 2017, because there was only partial compliance with NICE guidelines on violence and aggression and short term management in mental health.
The hospital followed the ‘fit to sit’ policy for people coming in by ambulance. This meant encouraging people to walk if they could, and to sit rather than lie on a trolley. This helped establish a recovery mind-set, and helped avoid causing muscle loss in patients, especially frail older people.

We saw that the trust had carried out a detailed review and update of the trust’s e-learning packages following the publication of the NICE guidance on sepsis (July 2016).

The department undertook regular audits. These included national audits requested by the Royal College of Emergency Medicine (RCEM); others were based on NICE guidance such as pain management and hand hygiene. There was a medical research group who audited clinical practice in the ED with the aim to improve patient care.

19 audits had been completed during the last audit year (1 April 2016-31 March 2017). On this inspection we found a clinical audit programme in place, but work on four out of six national audits and two out of five local audits had not yet been started. The department was currently participating in the neck, femur fracture audit and procedural sedation audit.

Nutrition and hydration

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 01/09/2016 - 30/09/2016)

Water was available in most areas of the department. Water was the only refreshment in the ED waiting area. There were no refreshments in the paediatric ED so patients and their families had to ask the receptionist for a drink. In majors there were regular checks on patients’ fluid intake. We observed patients with drinks at their bedside.

Patients were offered food and drink where appropriate if they were in majors at mealtimes and medically cleared to eat.

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.

Pain relief

The Faculty of Pain Medicine standards say that acute pain must have an individualised pain plan appropriate to their clinical condition that is effective, safe and flexible, and that all in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs. We saw evidence of staff in majors carrying out comfort rounds to assess people’s comfort, including pain and recording this in their notes in line with the faculty’s recommendations. We saw staff asking patients if they were in any pain.

In paediatric ED a pain assessment chart, the Brief Pain inventory, was on display, as well as the rapid pain assessment score for children over seven years old and the five faces for children under five. However, none of the eight sets of children’s notes we reviewed contained a pain score, even when analgesia was recorded as given. This was contrary to trust policy.

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 01/09/2016 - 30/09/2016)

Timely pain control in the EUCC was an area for improvement. One patient told us they had no follow up assessment of pain even though they had been in the EUCC for over three hours. Another said staff had not asked about her pain level in the two hours she had been waiting. Clinicians did not always offer children pain relief at streaming.

Nurse practitioners told us that in the EUCC pain relief was only given at the complex streaming stage. This increased patient’s waits for pain relief.

**Patient outcomes**

The hospital took part in several of the RCEM audits so that it could benchmark its practice and performance against best practice and other urgent and emergency departments. As the audits in 2016/7 were mainly different from the 2013/4 audit results reviewed at the previous inspection, no direct comparison was possible.

In the 2016/17 Moderate and Acute Severe Asthma report, Queen’s Hospital failed to meet 100% in any of the audit standards.

The hospital 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. Hospital Score: 96%; UK: 77%.
- Standard 5a: If not given before arrival to the ED, steroids given thin one hour of arrival (where an acute severe attack has taken place). Hospital Score: 40%; UK: 19%.
- Standard 5b: If not given before arrival to the ED, steroids given within four hours (when a moderate attack has taken place). Hospital Score: 47%; UK: 28%.

The hospital 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 ED. Hospital Score: 10%; UK: 25%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital Score: 25.4%; UK: 52%.

The hospital’s results for the remaining two metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit Queen’s hospital was in the lower UK quartile for one standard:
• Proportion of patients aged under 1 with a fever seen by a Consultant. Hospital Score 0%, national median 8%.

The hospital’s results for the remaining three standards were between the upper and lower UK quartiles. 
(Source: Royal College of Emergency Medicine)

In the 2016/17 severe sepsis and septic shock audit, Queen’s Hospital was in the upper 25% of trusts for one standard:

• 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. Hospital Score 94%, National aggregate 69%.

Queen’s hospital was in the lower UK quartile for four standards:

• Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital Score 45%, National aggregate 65%.
• Standard 4: Serum lactate measured: Within one hour of arrival. Hospital Score 31%. National aggregate 60%.
• Standard 5: Blood cultures obtained: Within one hour of arrival. Hospital Score 5%. National aggregate 45%.
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital Score 1%, National aggregate 18%.

The hospital’s results for the remaining three metrics were all between the upper and lower UK quartiles. 
(Source: Royal College of Emergency Medicine)

However, the department’s local audit in 2017 following significant focus on sepsis treatment and management to improve patient care, showed much improved overall performance.

• The trust achieved 90% or greater in serum lactate measured.
• Blood cultures were achieved within 1 hr in 84% of cases audited.
• Urine output was measured within four hours in 14% of cases.

NHS England had recently commended the trust for being one of the trusts which had seen the greatest improvements in performance in assessing and treating sepsis within its emergency departments.

In the 2015/16 Vital signs in children audit, Queen’s Hospital failed to meet 100% in all of the standards of 100%.

The hospital was in the upper quartile for one standard:

• All children attending the emergency department with a medical illness should have a set of vital signs consisting of: Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. Hospital Score 51%, England median 38%.

The hospital was in the lower quartile for four of the standards:
• Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Hospital Score 0%, England median 4%.

• There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital Score 14%, England median 70%.

• There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital Score 51%, England median 73%.

• Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital Score 29%, England median 60%.

The hospital’s result for the remaining metric was between the upper and lower England quartiles.
(Source: Royal College of Emergency Medicine)

Patient notes we looked at on this inspection showed children’s vital signs were routinely recorded in ED.

In the 2015/16 Procedural sedation in adults’ audit, Queen’s Hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the upper England quartile for one standard:

• Following procedural sedation, patients should only be discharged after documented formal assessment of suitability is provided. Hospital Score 15%, England median 3%.

The hospital was in the lower England quartile for three of the standards:

• Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status, Hospital Score 0%, England median 8%.
• Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital Score 33%, England median 90%
• Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG. Hospital Score 0%, England median 24%.

The hospital’s results for the remaining three metrics were all between the upper and lower England quartiles.
(Source: Royal College of Emergency Medicine)

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, Queen’s Hospital was in the upper England quartile for one standard and the lower quartile for the other standard:

• Upper quartile: If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Hospital Score 100%,
England median 100%.

- Lower quartile: Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. Hospital Score 0%, England median 2%.
  
  (Source: Royal College of Emergency Medicine)

At the last inspection we found the unplanned re-attendance rate (number of patient re-attending within seven days of a previous attendance at A&E) at Queens Hospital between May 2015 and April 2016 was between 10% and 11%. This was consistently worse than the England average of 7.6% and worse than the national standard of 5%.

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to A&E within seven days was similar to the previous year. It was generally worse than the national standard of 5% and worse than the England average over the whole period. This trust’s performance in this metric saw a slight improvement over this period towards the average for England.

(Source: NHS Digital - A&E quality)

Competent staff

There was a focus upon teaching, learning, and professional development in the department in both the medical and nursing teams.

There were set times each week for junior doctor training within the department, and one of the consultants was a lead in emergency medicine for the London network. Consultants prioritised junior doctor education, training sessions were mandated and not cancelled, and training was of a good quality. Junior doctors confirmed this, although on an exceptionally busy day in February a doctor said he had missed part of a training session. Trainees took turns to present the ‘case of the day’. A trainee doctor commented upon the high levels of support from consultants. Junior doctors completed forms on their experience of working in ED and their training to monitor the training experience.

Practice development nurses (PDN) supported nurse education within the emergency department. The department had set up a new intern programme to provide pastoral support, coaching and mentoring for newly qualified nurses to prevent them becoming demotivated and ultimately
leaving. This had been a success and two additional nurses had been recruited to expand the scheme. Emergency nurse practitioners said there was a new teaching programme for practitioners every Tuesday and alternate Thursdays.

New nurses and support staff were required to complete competencies before being allowed to work in specific areas of the department, such as the resuscitation room. New junior doctors had a full induction day that included safeguarding, ambulatory care package, complaints and clinical governance, sepsis, pharmacy, life support and a tour of the department.

Agency nurses said they had a tour of the department and followed an induction checklist before starting their shift. There was a local induction checklist for doctors. However, we spoke with three locum doctors who reported having minimal induction, one GP in the EUCC, another in rapid assessment and a consultant in majors. All doctors said they just had a quick talk through the day’s responsibilities.

Some staff were trained in conflict resolution and others were booked on breakaway training. Nurses who had undertaken this training reported that it was valuable for working in ED. A small proportion of staff had done dementia training.

Following several incidents, a skills gap had been identified in plaster cast application so all staff involved in this were being retrained. This indicated responsiveness to monitoring information.

Nurses attended structured ‘keep in touch’ training days four times a year and this included training on incidents, SIs and complaints, and training on governance to discuss data and what could be learned from it.

Staff we spoke with said they had not received formal, comprehensive training on mental health. One member of staff said that mental health was covered in the safeguarding training. Another said they had had some mental health training when they joined the trust. The service had invited colleagues from the mental health team to attend a training day. Senior staff told us the mental health component of the training for nurses was under review.

The trust subsequently told us that there was mental health training on KIT days as well as face to face enhanced training on situations that could arise in ED. Just over half of permanent nurses had experienced this training as shown in the table below.

<table>
<thead>
<tr>
<th>Band</th>
<th>KIT day training (MH)</th>
<th>Enhanced training (MH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 7</td>
<td>54%</td>
<td>54%</td>
</tr>
<tr>
<td>Band 6</td>
<td>77%</td>
<td>63%</td>
</tr>
<tr>
<td>Band 5</td>
<td>59%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Information provided below covers the trusts ‘Acute Medicine’ of which urgent and emergency care was part.

From April 2017 to October 2017, 84% of staff at the trust had received an appraisal compared to a trust standard of 85%. A breakdown of appraisal rates by staff group is below:
<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Number of individuals trained - Apr 17 to Oct 17</th>
<th>Sum of Number of individuals required - Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Trust standard</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scientific and Technical</td>
<td>1</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>329</td>
<td>367</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>154</td>
<td>201</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>87</td>
<td>98</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>571</strong></td>
<td><strong>671</strong></td>
<td><strong>84%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

On inspection we learned that the division had achieved the appraisal standard of 85%. The process was known as the positive performance review process and assessed all staff against the trust’s values. Nurses told us the process encouraged them to learn from the previous six months and identify what had worked well and what they could improve.

We were told that locums had a paper based feedback/appraisal system but that managers were in the process of developing an online system that would allow for centralised recording and reporting.

**Multidisciplinary working**

There was a strong ethos of multidisciplinary working, and the benefits of close teamwork and cooperation were evident. We observed this in our last inspection and saw that this ethos was still present on this inspection.

Allied health professionals including physiotherapists and occupational therapists reviewed patients within the emergency observation unit (EOU) to check referrals and help facilitate discharge. We saw discharge planning carried out jointly between medical staff, nursing staff and occupational therapy. One patient required a mobility assessment and occupational therapy, and we saw staff conduct a thorough assessment including communicating with patients’ relatives about the home environment and support.

We observed good patient handovers between staff within the emergency department and between hospital and ambulance staff.

We saw that the ED had a good working relationship with other hospital departments to support patient care.

We found evidence of effective working with external organisations such as primary care GPs, community safeguarding teams, the police, and ambulance services. The Community Treatment Team was based in ED to respond quickly to patients who were likely to be able to continue their care and assessment out of hospital. These patients could then have an assessment for their longer-term needs at home, and if necessary receive a community care package. A Frail Older Persons Advice & Liaison service (FOPAL) in the medical assessment unit provided comprehensive geriatric assessment for frail elderly people, seeking to avoid keeping people in hospital where possible.

BHRUT worked in partnership with the local mental health trust which provided a 24/7 in-reach service. It delivered a psychiatric liaison service to provide mental health assessments, referrals, care and treatment to patients aged 18 or over. Staff working for this service were based at
Queens Hospital. A service level agreement between the psychiatric liaison service and the ED had been in place since 2015. The agreement included a standard for the psychiatric liaison service to respond to 95% of requests to assess patients within one hour. At the time of the inspection, the service was achieving this standard. The service did not see patients who were unresponsive or intoxicated. In these circumstances, the service would see the patient once they were responsive or the toxicity had declined. The service carried out psychosocial assessments in accordance with national guidelines.

The Acute Medicine Divisional Nurse and one of the Associate Speciality Managers attended partnership meetings with the mental health trust to review cases, attendance numbers and re-attendees, to formulate care plans for individuals.

The paediatric service could refer patients to a specialist child and adolescent mental health service (CAMHS) between 9am and 5pm from Monday to Friday. The CAMHS service usually attended within one hour of ED staff requesting an assessment. Outside these hours, staff could contact an on-call specialist psychiatrist. If a patient required an admission to an inpatient CAMHS service, there could be delays while staff waited for a bed to become available. The lack of acute psychiatric beds for children under 16 years old who required admission to the acute psychiatric unit resulted in excessive length of stay and poor patient experience. This was a risk rated moderate on the ED risk register. If patients were in ED for an extended period, the service could allocate specialist mental health nurses from an agency to care for the patient. These agency nurses could attend within one hour. Alternatively, the service could admit paediatric mental health patients to the general paediatric ward.

Staff working for the ED and staff within the psychiatric liaison said the two services enjoyed a good working relationship. Staff in the paediatric ED reported a very good relationship with the CAMHS service.

**Seven-day services**

The EUCC was open 24 hours a day. At the previous inspection it had closed at midnight.

The emergency department was open 24 hours a day throughout the year. This was for both adults and children. There was 24 hour access to CT and an on-site radiographer available 24 hours a day. Between the hours of 11pm and 8am, the reporting radiographer was on call accessible through the switchboard.

There was 24/7 consultant cover at Queen’s ED at least five days a week, with one consultant at night after 11pm. There were always on call consultants.

For children, there was consultant paediatrician on site 6 days a week, as well as on call cover from a paediatric consultant 24/7, in addition to the ED consultants.

An emergency eye clinic was held Monday to Friday only. There was no weekend emergency ophthalmology, so patients came to the emergency department when this was closed.

Clinical pharmacy services were available seven days a week with shorter hours on Saturdays 9am and 3pm and on Sundays 9am and 12pm. An on-call pharmacy service was available out of hours. Staff had access to emergency stocks of medicines at all times.

Most therapists worked five days a week although there was limited physiotherapy at weekends.
Health Promotion

At the last inspection, we found ED staff worked closely with local GPs to stream patients effectively, including back to their own GP. On this inspection we saw only a few patients referred to their own GP or being advised about GP hubs for out of hours treatment.

There were some leaflets available for patients within ED and EUCC which staff could give patients and carers. For example, the paediatric emergency department had developed an information leaflet for parents and carers about common childhood illnesses and injury and when to seek help.

During our inspection, there was information on the display screen in the waiting room about smoking prevention, cervical cancer screening, asthma and the outpatient pharmacy. There was also information for patients about self-care including speaking to a pharmacist, or visiting a GP or walk-in centre before considering urgent care at a hospital. There was also information about the journey through the hospital’s emergency department. However, on our second visit to the EUCC in February this information screen was not working so no public health information was displayed. There were no posters in this area about local services.

Staff hoped the reconfiguration of children’s ED (where more children were seen by a GP) would help improve patients’ health literacy and understand what a GP can do and what required referral to a hospital doctor.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff we spoke with had a good working knowledge of the law around consent. The nature of emergency medicine dictated that there were rare occasions when written consent was required. Staff were therefore focused upon patients giving them verbal or implied consent. We observed verbal consent taking and appropriate recording, including consent for inspectors to observe streaming. Some records of people in majors did not have consent recorded, which was out of line with trust policy.

The trust policy on Consent to Examination and Treatment set out the process for obtaining informed consent from, or on behalf of, patients, and how to proceed when a patient could not consent.

The trust set a standard of 90% for completion of MCA/DOLS training.

We found on inspection that 89% of ED staff had completed training on the Mental Capacity Act. Some staff showed understanding of the principles of the law for patients who were not able to make their own decisions, but not all staff recalled having this training. Staff said that if they had any questions about the use of the Mental Health Act or Mental Capacity Act, they sought advice from the psychiatric liaison team.

The mental health team or doctors carried out mental capacity assessments. Some clinicians carried out brief mental capacity assessments known as ‘mini-mental state’ assessments for patients who may have dementia.

The trust policies for Safeguarding Adults and for Safeguarding Children detailed how to identify a patient who did not have the capacity to give consent, including applying Gillick competency checks for young people. This is when it is appropriate for consent to be obtained from a child under the age of 16 without the knowledge or authority of the parent.

We reviewed the record of a patient aged under 16. The record showed that staff had administered rapid tranquilisation to this patient. Staff told us this had been carried out whilst they restrained the patient. Staff had not recorded the legal authority under which they had
administered the injection. There was no record of staff assessing the competency or capacity of the patient. The record did not include details of any discussion with the patient’s parents.

The trust did not have a policy on the Mental Health Act. Nor did the department keep records of occasions on which the police bought patients to the ED to provide a place of safety under section 136 of the Mental Health Act (MHA).

Is the service caring?

Compassionate care

Most of the patients we spoke with were very pleased with the support from staff. We observed several interactions between patients and staff and saw staff speaking to patients in a kind and reassuring manner, taking time to listen to what they had to say.

There was lack of confidentiality when patients registered. On several separate occasions over three days we saw a queue of five or six people registering at reception. The noise level in the waiting room, combined with the glass safety screens, forced patients to speak loudly to ensure registration staff could hear them. This meant others in the waiting room could overhear personal details. There was no restriction on queuing at the desk. There was a further risk to confidentiality in the streaming area. Patients in the simple streaming pods could not be overheard in the waiting room, but patients in those pods could overhear others having complex assessments, as staff kept the door open for their own safety.

We saw one person asked to use the waiting area toilet to provide urine sample which compromised dignity. There were toilets in the clinical area which staff could have suggested a patient use.

All patients were offered a patient experience questionnaire which includes the FFT question to complete at the point of discharge if attending the emergency department.

The trust’s urgent and emergency care Friends and Family Test performance was generally worse than the England average from November 2016 to October 2017, but performance improved between June and August 2017. In December 2017 73.7% recommended care in the emergency department against a trust standard of 85%:

(Source: NHS EnglandFriends and Family Test)
We observed staff maintaining patients’ privacy and dignity by keeping them covered and drawing curtains during examinations and procedures.

All staff treated patients in a compassionate and courteous way and patients remarked the kindness of staff even when they had very long waits.

There was not enough privacy for patients and their relatives or friends in the waiting area. Even though demand for emergency services was high the size of the reception area was less than half the size of the waiting area at the trust’s other urgent and emergency care service. However, we acknowledge that the CQC inspection took place during high winter pressures across the country, and that the waiting area was not permanent. A series of expansions in the trust’s emergency care provision would improve this over time.

**Emotional support**

At the last inspection we observed some negative staff behaviour in the emergency department at Queens Hospital. We did not observe such behaviour on this inspection. Staff were seen to behave compassionately and with understanding towards people attending the ED. Staff said they were committed to helping patients recover. Staff also said that nurses had a good level of empathy towards patients.

The bereavement service produced a pack for when a patient passed away. This gave information for families on what to do following a death, and signposted support services. If a child passed away the family could receive a bereavement box with hand and foot prints. Staff held round table meetings when there was a sudden unexplained death and there were debriefs for staff. Staff offered a supportive response to patients and their families to help them deal with their feelings, emotions, and attitudes during times of illness and loss.

A multi-faith chaplaincy service provided service for patients and their families. Patients and visitors could access a multi-faith prayer room on the hospital site.

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

Staff communicated clearly with patients to help them understand what was happening to them. They kept relatives and people accompanying patients informed.

Patients said they were able to ask questions and raise concerns. Most of the concerns patients had on our inspection were about the waiting times. Three patients we spoke with in majors said they were being well looked after and were comfortable and that doctors were keeping them informed about what was happening.

However, in the EUCC some patients told us they did not understand the EUCC process and how long it would take. However, at discharge stage we saw that staff checked that patients understood their treatment and told them what to watch out for at home.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 12 of the 24 questions and 12 of the 24 questions worse than other trusts in questions relevant to caring. A summary of all scores under the caring domain is 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>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------</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>Q24. 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>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>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
--- | --- | ---
Q45. Overall... (please circle a number) | 7.3 | Worse than other trusts

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

During the last inspection of Queen's Hospital ED we noted the waiting areas were very full and there were few chairs available for patients. On this inspection a new waiting area had opened but there was still insufficient seating for the number of patients. The opening of a new children’s waiting area during our inspection slightly eased the overcrowding. However, at the time of our inspection, ED was experiencing above average attendance as it was winter, and the pressure on emergency departments nationally was high.

Patients registered at reception, then waited for streaming. In the reception area staff were seated behind a desk area with two heights, which meant people who used wheelchairs were able to be treated respectfully.

After registration, patients were called for a quick clinical assessment (simple streaming), at which a few patients were referred immediately to the emergency service. The streaming pods gave visual privacy to patients, but not auditory privacy when the waiting room was full.

The initial streamer, who was paediatric competent streamed to a number of different areas, ie EUCC GP, Minor Injuries, EUCC, Majors/RAFTing, Resuscitation, Paediatric ED, Ambulatory care or in some cases redirecting patients to their own GP. Another queue was patients waiting for reviews for trauma (three mornings a week). This last review stream put extra pressure on the emergency waiting space.

Patients streamed to majors or EUCC had further assessment (complex streaming) in line with RCEM guidelines. At that point the acuity and priority of the patient was assessed, and investigations (such as requesting blood or radiological tests) were initiated.

Patients returning to the same waiting area after interventions such as blood tests and X-rays put additional pressure on the seating in the waiting area.

As at the last inspection, we found there were a number of specialist teams available, including a frail and older person’s advice and liaison team and an ambulatory care unit who assessed and treated people who did not need hospital admission. The trust continued to host a 24/7 psychiatric liaison service (PLS). This team worked closely with ED staff to improve the quality of care experienced by those patients who presented to the department and had an associated mental health illness.

Patient information leaflets were not on display in languages other than English, but there was a facility to translate these into 137 languages. The top 4 languages were British Sign Language (BSL), Bengali, Punjabi, and Romanian. Staff told us telephone translation services were always available and face to face translation could be arranged. In addition, staff had facilities to support patients in communicating decisions by using communication boards and pictures. The service could access staff trained in accessible sign language. The trust also employed a specialist learning disability nurse who could provide additional support to patients.
Meeting people’s individual needs

The trust complied with the Accessible Information standard by ensuring that people with a sensory loss, impairment or disability were given information they could easily read or understand. If a person had attended the hospital before their communication needs would be on the patient record. A poster in the waiting room encouraged people to say how they preferred others to communicate with them, for example by using communication boards and pictures, or in another language. The department could access staff trained in sign language.

Staff said sometimes patients came with ‘patient passports’ which was useful. The trust was aiming for 95% of all patients with a learning disability to have a patient passport.

At the entrance to the ‘majors’ area of the department there was a notice board welcoming patients and explaining comfort rounds and meal times. There was a poster on waiting times to manage expectations and a poster with an explanation of different uniforms. Elsewhere in the ward area, there were patient information leaflets on conditions such as head injury and services such as drug and alcohol support and talking therapies. Another board showed information on the quality of care including friends and family tests results.

A welcome board in the paediatric ED showed a range of relevant information for parents such as staff names, waiting times and information about safeguarding and keeping a child comfortable. There were facilities for breastfeeding and toilets with nappy change area. There were vending machines in former ED waiting area nearby. In the paediatric waiting room there was a TV screen showing child appropriate content.

At the time of inspection two electronic screens in the waiting room showed the BBC news and trust news. People we spoke with did not understand the investigation and treatment process, or have any idea of waiting times. We were told waiting time information would be displayed, as well as information explaining the current waiting arrangements were temporary. We were also told signage would be improved so visitors coming to see a patient in the main ED could find their friend or family member, which visitors told us was difficult at present. When we returned to visit ED in February the trust information screen was not working so there was no information about waiting times. There had been no improvement in signage.

The service held meetings to discuss frequent attenders which enabled them to put a care management plan in place.

We saw some patients on trolleys in corridors while awaiting X-ray which was not dignified. When the emergency department unit was busy we saw some patients having observations taken in a corridor. Where possible, patients waited to be treated sitting rather than lying down.

The rapid assessment team could not always keep up with the number of patients coming in, although they did prioritise and assess people as safe to wait. Some staff said initial treatment would be begun as relevant, but other staff told us this was not the case.

The emergency department was not dementia-friendly in terms of signage, dementia-friendly clocks or matt flooring in either the main department or the EUCC.

or the EUCC but the observations ward (two bays of the elderly admissions unit) had clocks showing whether it was day or night to help orientate patients living with dementia.

We reviewed a booklet for staff on end of life care. Staff could make contact with the chaplaincy on behalf of families.
There were two relatives’ rooms available in the resuscitation area where confidential conversations could take place. If a patient passed away there was a viewing room in the resuscitation area.

The trust scored “worse than” other trusts for two questions on privacy relevant to the responsive domain, questions 7 and 20 of the Emergency Department Survey. The trust scored “about the same” as other trusts for the question on the length of visit.

<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 01/09/2016 - 30/09/2016)

Access and flow

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 ED.

Staff at Queen’s continued to be unable to meet the government’s four hour standard across the urgent and emergency department because of staff shortages, the space available and the volume and acuity of patients. In the last 3 months of 2017 the UCC treated and discharged 85% of patients in 4 hours and the emergency department on average 70%.

Staff were working in partnership with community health services to reduce length of stay, and expected the expanded EUCC and larger ambulatory care area would improve non-admitted performance. The department had reported some improvement in performance since the previous year.

From December 2016 to November 2017 the trust’s performance against the four hour standard showed considerable fluctuation and was below the average for England and the NHS standard. Up to August 2017 the year average was 86.83% but performance had then fallen. On inspection we found the score for December 2017 was 76.7% compared to a national average performance of 85.1%. In January 2018 the performance against the four hour standard fell further to 71.3% compared to a national figure of 77%. The trust was aiming for 90%:

![Graph showing performance against four hour standard](image)
The main causes for deterioration in performance were the number of complex and acute patients needing beds. One of the key issues stopping the flow was the number of patients that should not be in an acute bed such as specialist/neuro rehab patients waiting to be transferred to appropriate specialist centres, end of life patients, and patients awaiting continuing healthcare funded placements and nursing home assessments.

It was clear that ownership of patient flow was accepted as a hospital wide issue and a collective approach was being taken. We attended one bed meetings, which were held three times a day and involved staff from all areas of the hospital. During this meeting, both hospitals in the trust discussed the number of patients in ED, staffing levels, any emergency department breaches and bed capacity. This allowed the trust as a whole to identify capacity issues, and ways to resolve these.

For patients expected to need a short admission, under 48 hours, there was a medical receiving unit (MRU), a ward for emergency medical patients. There was also a separate elderly short stay unit. ED had strong working relationships with both wards. We attended a meeting where patients in MRU were reviewed to assess their medication and scope for early discharge. However, staff believed a much bigger medical receiving unit was needed to cope with the number and acuity of patients attending as emergencies.

At the last inspection, ‘streaming’ had been introduced (a process designed to fast track patients from reception to the right places, such as minor injury, a GP, or majors). The purpose of streaming was to prevent people waiting when it might not be required, and minimise overcrowding. However, the streaming was itself one of the bottlenecks in the system. During a period of observation in EUCC waiting times were between 20-60 minutes for complex streaming (triage). We saw a few people waited for four to five hours in urgent care where typically we would expect much shorter treatment and discharge times. However, at the time of our inspection the department was experiencing exceptionally high levels of demand, and increased acuity of patients.

There was a system for patients coming to EUCC for appointments and review, rather than attending outpatient appointments which put additional pressure on patient flow through EUCC.

Staff were aware of other blockages to flow through ED, such as time waiting for blood test results, delays in radiology, response from speciality teams for either assessment or admission, and shortage of inpatient beds. Staff stated they hoped that point of care blood testing, giving more
rapid access to common blood test results would have a significant impact on flow by reducing the wait for results to 12 minutes rather than the current hour or more. Although this system was due to be in place by end January 2018, it had not started by 8 February 2018 so we were not able to test this on inspection.

We found some inefficient processes in place. For example, clinicians told us that when they requested a CT scan they invariably had to chase the CT report afterwards. Staff in radiology said that when clinicians requested urgent CT scans (which according to policy should be within 30 minutes), there were often delays before the patient was brought for scanning. The radiology service itself used two different computer systems, neither of which interfaced with the ED patient record system. Although the radiology service told us they prioritised requests from ED, they also carried out all other hospital scanning, so there were many competing pressures on reporting radiographers. Although the trauma policy said that a provisional CT report should be available within an hour, staff told us this was often not achieved. There did not appear to be delays in reporting on skeletal x-rays.

Those carrying out diagnostic tests appeared unaware of the time taken for results to reach ED clinicians. There appeared to be scope for greater analysis of the impact of diagnostic processes on patient flow through ED.

There was an electronic system to request porters in ED. Some doctors and nurses did not know how to use this system, and porters themselves said the system regularly crashed. But as porters were only permitted to take requests made electronically, and not by telephone the process led to inefficiency and delay.

Different specialties had different contact methods, which was potentially confusing for ED clinicians. For example, staff had to request a neurosurgeon’s attendance by email but other requests could be made by telephone.

A potential delay to prompt treatment occurred because of the geographical distance from EUCC to ED. EUCC staff had to push patients round to ED (which took approximately six minutes). Some staff considered there was a psychological barrier caused by the distance between the EUCC and ED, such that ED staff did not feel ownership of problems in the EUCC.

When patients registered in EUCC there was no protocol in use by reception staff for immediate referral to ED; for example, adults with chest pain, patients undergoing chemotherapy and babies under a month old with jaundice. All had to go through simple streaming before referral. However, the trust subsequently told us that this protocol should be operated by staff registering patients at reception.

Paediatric staff were concerned that the streaming process delayed child referrals. In the paediatric notes we reviewed, only two children out of eight were streamed within 15 minutes of arrival. Staff gave us examples of two recent delays in transfer. One was a child with sepsis and another was a child who was having fits. There were no paediatric nurses in EUCC and only one GP was able to review children. We were also told that the previous open access for certain children to attend the paediatric ED or to go direct to a ward was no longer possible.

The paediatric ED saw, treated and admitted or discharge most children within four hours in September 2017. Paediatric specialists in ED saw 90% of children within 30 minutes, with an average wait of 38 mins.

From December 2016 to November 2017 Barking, Havering and Redbridge University Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision
to admit until admission was better than the England average. Performance against this metric was maintained with neither improvement nor decline over the period. (Source: NHS England - A&E Waiting times).

24-25% of patients attending ED were admitted as inpatients.

During the inspection we saw varying numbers of patients in ED waiting more than eight hours from admission for a bed on a hospital ward. For example, at one point in the morning we saw that 10 patients had stayed in majors for 12 hours before a bed was identified, and 18 waited over eight hours. All patients who had waited on trolleys for over five hours were given beds. Speciality teams reviewed patients waiting in majors for admission.

Between December 2016 and November 2017 two patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in December 2016 and January 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2016</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>January 2017</td>
<td>108</td>
<td>1</td>
</tr>
<tr>
<td>February 2017</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>March 2017</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>April 2017</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>May 2017</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>June 2017</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>July 2017</td>
<td>90</td>
<td>0</td>
</tr>
<tr>
<td>August 2017</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>September 2017</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>October 2017</td>
<td>57</td>
<td>0</td>
</tr>
<tr>
<td>November 2017</td>
<td>76</td>
<td>0</td>
</tr>
</tbody>
</table>
The decision to admit (DTA) was made by speciality teams and not by ED consultants. Response times from specialists were seen to be reasonably prompt. Only patients requiring more than 48 hours of care were admitted to a specialised ward, to improve bed capacity and support the flow of patients to help meet ED standards. Other patients were admitted for short stays in the Medical Receiving Unit and Elderly Receiving Units, or the medical assessment unit. Patients who were judged likely to be able to return home that day, following further assessment and medical treatment could be seen in the ambulatory care unit that was open until 8pm.

The Community Treatment Team was based in ED to respond quickly to patients who were likely to be able to continue their care and assessment out the hospital. These patients could be assessed for their longer-term needs at home, and if necessary receive a community care package. A Frail Older Persons Advice & 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 was working on the frailty pathway with the CCG to avoid unnecessary admission for elderly patients and it was expected this would also support capacity for end of life care.

Although the aim was for speciality doctors to assess emergency patients within 30 minutes, they did not all attend within this time. We were told there were longer response times from the surgical speciality but we saw generally good response times and reviews in majors during our inspection. Staff reported all delays in specialist response times as incidents, as well as delays due to bed capacity.

From November 2016 to October 2017 the monthly percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average each month; however, in October 2017 the trust’s performance for this improved to a rate similar to average for England.
To assess waiting times for mental health patients attending ED we reviewed five records for patients with mental health issues, selected at random. Children waited longer than adults. One record was for a patient bought in by the police. This patient was assessed straight away and discharged after 20 minutes. Two patients were bought in by ambulance. A clinician saw one of these patients after 59 minutes. The police accompanied the other patient. An ED consultant saw this patient after 30 minutes. However, paediatric patients had to wait for long periods of time for psychiatric assessments. One patient, aged 15, was triaged within six minutes of attending the urgent care centre but had to wait over five hours to be seen by a psychiatrist. Another patient, also aged 15, waited 57 minutes to be triaged. The patient then waited a further four and a half hours to be seen by a psychiatrist.

Learning from complaints and concerns

From October 2016 to September 2017 there were 105 complaints about urgent and emergency care services at Queen’s. The trust took an average of 27 working days to investigate and close complaints, this was in line with their complaints policy, which stated complaints should be closed within 25-40 working days.

Each formal complaint investigation was documented on the trust’s Risk Management database. Formal complaint responses were checked by either by a senior member of the division or by the Divisional Quality and Safety Advisor.

Complaints were reviewed to identify themes emerging. The main themes were about diagnosis and treatment and attitude of staff. Staff told us complaints about communications and staff behaviour had reduced.

A breakdown of formal complaints for urgent and emergency care by subject is below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Cross Site</th>
<th>Queen's Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Care process</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Waiting times in A&amp;E</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Waiting times for IP admission</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Waiting times for scans/tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety - Accidents</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Safety - other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>105</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

On inspection we found the 237 written complaints during 2017 were responded to in a timely way. We observed staff speaking with complainants by telephone to explain and apologise where something had gone wrong.

Staff collated positive comments which they reported to staff in a newsletter. The hospital had received about 55 written compliments during 2017.

We observed many patients making informal complaints about waiting times in the EUCC.

**Is the service well-led?**

**Leadership**

The emergency department was part of the acute medicine division within the trust. A clinical director, a divisional nurse and a divisional manager jointly ran the acute division. They reported to the Board through the chief operating officer.

ED had a general manager and a clinical director. These roles along with the service director worked across the two hospital emergency departments. Locally, nurse leadership was from two lead matrons who split responsibility for the different emergency department areas between them. More senior ED staff said they had good support from the senior team, but not all junior staff felt their voices were heard.

The trust had introduced Leaders’ Agreement, launched in November 2017. This was a set of expected behaviours of our leaders and a commitment to supporting and developing leaders. There had been a number of recent managerial appointments, mainly from within the trust, to provide continuity. Staff we spoke with considered clinical leaders had made some improvements and said the clinical medical lead set high expectations of staff and led by example.

The trust was responding to its staff survey results and WRES data by exploring opportunities for senior leadership positions and general career progression for BME staff.

Leadership training for ward managers was now being introduced for shift leaders in ED.
Some clinicians expressed concern about leadership of the EUCC which seemed to have taken insufficient account of clinicians’ views in the process and design, and not sought the views of those working in the area about how to adjust the arrangements so they worked more effectively.

Vision and strategy

At the last inspection we found a lack of clarity on the vision and strategy at department level. The trust told us subsequently that ‘enabling strategies’ to support the Trust’s overall vision were in the final stages of development or refresh.

We did not see a written vision at ED level, but staff told us their aim was to provide excellent emergency care supported by comprehensive urgent care services 24 hours a day, seven days a week. This was combined with admission avoidance measures that were successfully reducing admissions such as ambulatory care, extending A&E consultant presence and where possible redirecting walk-in attendees to primary care and encouraging self-care.

There were plans for capital expenditure in six phases to expand the capacity of Queen’s to manage the growing volume of patients in both emergency and urgent care. Staff told us their plans were in the context of a wider regional review of urgent and emergency care which, when settled, would help refine the trust strategy. The current regional strategic transformation plan had included the downgrading of King George Hospital to an urgent Care Centre, with Queen’s Hospital becoming the primary accident and emergency service. We were told this plan was now under review.

Manager’s immediate objective was to get the flow right so the right patients were seen, in the right place, in a timely way. The strategy included attracting, developing and retaining staff which were a pre-requisite for improving flow. Workforce was on the agenda of all governance meetings.

A paediatric assessment unit was in development and likely to be located in an area adjacent to the paediatric ED. Staff were also working on a revised plan for paediatric attendances to go to the main entrance of the former ED to change the flow of the system.

Culture

The majority of staff spoke positively about their experience of working for the trust. Staff said that their colleagues were very supportive. Staff also commented on the strong sense of teamwork.

Many staff mentioned the PRIDE values (Passion, Responsibility, Innovation, Drive and Empowerment) and their impact on developing a shared culture. There were a number of mechanisms for rewarding staff for exemplifying trust values in the workplace, a friends and family team of the week, PRIDE awards and Star of the Month.

Staff described a ‘no blame’ culture in relation clinical incident reporting. They reported learning from incidents and staff were able to identify changes in practice as a result of incidents.

The majority said there was a ‘can do’ ethic amongst clinical staff. However, clinicians considered there was a communication gap between them and non-clinical managers who often had unrealistic expectations of what staff could achieve within the resources and space available.

The response to the staff friends and family test (trust wide) in August 2017 was 83%. 76% of staff recommended the care given at the hospital but only 59% would recommend working there.

Governance
There had been improvement in governance in the emergency department following our previous inspection. Governance processes and structures were more clearly focused on priorities.

The chief operating officer chaired an emergency access delivery board to improve performance against the four hour standard. The trust had developed ED escalation plans (full capacity protocols) setting out clear pathways and processes for staff to follow when there was a failure to deliver patient flow through the department. Alongside this was a robust bed management policy. The trust had agreed that at times of unprecedented demand the ability to effectively manage surges within the ED should continue to be rated amber.

ED held monthly joint Business and Clinical Governance meetings and Quality & Safety governance meetings with set agendas to review incidents, risks clinical effectiveness, updates to NICE guidelines, and audits. Escalation from these meetings was to the Divisional Governance meeting and Divisional Quality and Safety group. Junior doctors attended Divisional Governance meetings to enhance their knowledge of governance. We reviewed minutes from monthly meetings and saw information about incidents was shared with staff through meetings, email and during handovers.

Matrons had regular and ad-hoc meetings to discuss issues within the emergency department and information was cascaded through a range of communication methods such as email, newsletters and meetings. There was a monthly senior sisters meeting.

GPs thought the management of EUCC did not involve clinicians sufficiently in management, and considered it difficult for staff at the frontline to get their voice heard. Reception staff and frontline clinicians told us they had not been involved in plans for the new EUCC, and felt non clinical managers did not listen to their concerns.

We had concerns about governance in relation to managing patients with mental health issues in the emergency department which was not adequately covered in policies or in staff training. For example, the trust policy on managing violence aggression did not refer to NICE guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings. We found no reference to rapid tranquilisation in the medicines policy or injectable medicines policy, and no mention of patients presenting with mental health issues in the Children’s Emergency Department Observation Policy. There was no policy on observation of adults in the emergency department, or on the Mental Health Act.

We had also concerns about triage of patients presenting with mental health issues, their immediate treatment and risk assessment in the time between triage and the arrival of mental health specialists, or in the period when ED staff were caring for patient for many hours whilst waiting for a transfer. ED staff did not have training in line with NICE guidance. There was insufficient managerial oversight of recording of restraint and of rapid tranquilisation, including recording the legal basis for actions.

**Management of risk, issues and performance**

The departmental risk register was reviewed monthly. The main areas of risk were the vacancies for clinical staff, the risk of non-compliance with the four hour standard, the physical capacity of ED, the risk of aggression to staff from patients with mental health presentation, and financial risk. This reflected what we found and we did not identify any risks that were not on the trust’s risk register. The trust was investigating whether the high use of agency staff and locums was a factor in serious incidents, to report this to commissioners. The report was not available at the time of inspection.
There was a management plan to ensure safe staffing by assessing acuity and need, and the trust RAG rated this each day. We saw plans to mitigate staffing risks as far as possible, and there had been some success in recruiting more permanent staff. Nonetheless there were regular staff shortfalls even though as many shifts as possible were covered by bank and agency staff.

The emergency department team meeting shared information about key performance indicators. For example, information about the four hour wait performance and ambulance turnaround times was displayed monthly on information boards.

The electronic observation system (VITALPAC) had significantly reduced the risk in relation poor response to patient deterioration.

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority. All staff were aware of this.

The site had a back-up generator supply for the loss of electrical supply, and uninterruptable power supplies (UPS) enabling them to function normally during the gap between grid failure and generator start up. Staff told us that fire alarms and the emergency generators were tested regularly.

**Information management**

The department was able to monitor performance of accident and emergency performance against the four hour standard throughout the day. This information was shared during bed management meetings. However, clinical staff were more focused on providing safe care than meeting standards which they did not feel they had the capacity to meet.

ED receptionists had to use four different IT systems. One was the hospital's main patient information system, to check patient details and previous hospital attendances. ED stored ED patient records and time and flow records on a computer system commonly used in urgent and emergency care settings. Yet another system, used in the local area in primary care, was used to register EUCC patients streamed to GPs. The hospital admissions list was a spreadsheet, and separate to the rest of the IT systems. Staff told us the new electronic system to record patient vital signs was not compatible with ED's patient system.

The ED IT system recorded information on initial assessment and timings. However, ED treatment records were paper based. Staff had to photocopy all the electronic records for patients requiring admission. Paper treatment records were not scanned onto an electronic system until archiving stage. Clinicians expressed concern that treatment information and diagnostic results held on multiple different systems made it difficult to see the whole patient picture.

**Engagement**

The trust encouraged a number of initiatives to foster public engagement including: ‘you said, we did’ boards and information on the website and on Twitter too.

Volunteers distributed forms to allow people to comment on their care and treatment.

The trust had set up a Patient Partnership Council which had emergency care as part of its focus, including care of children and people living in vulnerable circumstances. This provided a forum for feedback. The trust also ran listening events, with Healthwatch, to focus on the highest number of Patient Advice and Liaison Service (PALS) enquiries and formal complaints.

Leaflets around the department encouraged patients and relatives to participate in the friends and family test. Patients could also ‘share their story’ or complete the friends and family test online.
Staff told us they carried out ad hoc surveys of carers, patients and relatives, for example a bereavement survey.

Senior non-clinical staff told us the architect of the EUCC plans had held user groups and the board paper claimed the plans had been subject to full staff consultation and had been clinically signed off as the most clinically and operationally appropriate use of the space. However, very few staff we spoke with who were working in the EUCC, such as receptionists and streaming staff, had not been involved in discussions about tackling the current challenges in the new waiting area. We noted the staff survey found staff would like more involvement in decision making that affected them, but this did not seem to be happening.

Staff had briefings and regular newsletters to keep staff informed. A fortnightly e-newsletter ‘Emergency Bulletin’ was sent to staff. It covered news about the department including training, staff news and information about lessons learned from incidents, compliments, complaints and training. There was also a medical education newsletter for doctors.

However many staff mentioned that changes in accommodation were imposed at short notice without involving staff. For example, staff in ambulatory care were given two days’ notice of their move. While their new space was very much better, they would like to have been involved in the planning.

**Learning, continuous improvement and innovation**

The trust had two accolades in 2017. The paediatric emergency department was nominated for the Well Child Award, and the department achieved trust-wide peer review accreditation from the Trauma Audit and Research Network (TARN).

Staff were taking some innovative approaches to improving staffing, through taking on care support workers and training them to develop as Emergency Care assistants, and recruiting five apprentices to become band 2 support workers.

In the absence of funding for external training and development, staff were running internal training to build skills and capability. For example, emergency department assistants were undertaking nurse associate training and emergency care practitioners were doing physician associate training. Consultants were helping train nursing staff. The department were offering family-friendly hours and flexible working to help attract and retain staff.

The service had set up a flag on the electronic record that showed whether mental health patients had a crisis plan in place. Staff using the system could very quickly see what the crisis plan said and take appropriate action. This meant that staff could quickly identify patients who frequently attended the ED, and provide consistent care.

The department had become a research unit for adults and children, and already started research work.
Barking, Havering and Redbridge University Hospitals NHS trust provide a range of medical care services across their two main sites:

- **Queen's Hospital**: 15 inpatient wards with a total of 383 beds.
- **King George Hospital**: Eight wards with a total of 206 beds.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 61,123 medical admissions from September 2016 to August 2017. Emergency admissions accounted for 35,026 (57%), 1,061 (2%) were elective, and the remaining 25,036 (41%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 20,755 admissions.
- Gastroenterology: 13,711 admissions.
- Geriatric Medicine: 7,087 admissions.

(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**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Acute Medicine’ and ‘Specialist Medicine’ directorates across the whole trust.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from October 2016 to September 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>241</td>
<td>289</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Course</td>
<td>Total Participants</td>
<td>Target</td>
<td>Achieved</td>
<td>达标 (%)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------</td>
<td>--------</td>
<td>----------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>232</td>
<td>289</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>224</td>
<td>289</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>224</td>
<td>289</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>223</td>
<td>289</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>218</td>
<td>289</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>213</td>
<td>289</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was not met for any of the applicable courses for medical/dental staff.
A breakdown of compliance for mandatory courses from October 2016 to September 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>679</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>679</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>678</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>667</td>
<td>691</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>660</td>
<td>691</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>652</td>
<td>691</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>643</td>
<td>684</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Training targets were met by nursing staff for all applicable courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

After our inspection we asked the trust for more detailed information about mandatory training compliance. As of April 2018, 93% of nursing staff in the acute medicine division and 95% in the specialist medicine division had up to date training. In the acute medicine division 80% of doctors were up to date and in the specialist medicine division 87% were up to date.

Staff in sexual health services had an overall completion rate of 96% in February 2018. This was an average figure that reflected compliance at or above the trust 90% standard in every course except for information governance, in which 88% of staff were up to date.

Matrons and senior ward staff monitored mandatory training completion for their areas using an electronic system. This alerted them when staff training was due to expire within three months, which allowed them to plan ahead for training. Mandatory training was a combination of e-learning...
and face-to-face training and was also monitored through divisional governance and risk management processes.

Nursing staff met the trust’s 90% target in all areas of mandatory training, which reflected a significant improvement following more support and time for staff to complete courses. Medical staff did not meet the trust target in any mandatory training course. We spoke with doctors about this who said it was reflective of their workload. Divisional meetings reflected the need for an improvement in mandatory training completion although there was not a structured, time-specific plan in place to achieve this.

Locum doctors did not have access to all of the trust’s mandatory training programmes and divisional staff had highlighted that there was not a system in place to check this when doctors came to work in the hospital. A December 2017 action plan indicated a service manager was establishing a more structured system for ensuring locum doctors had completed key training courses.

The trust had an up to date policy for sepsis screening and antibiotic prescribing. This was up to date and all of the staff we spoke with either knew the policy in detail or showed us how they could access it.

**Safeguarding**

Safeguarding training completion rates are routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Acute Medicine’ and ‘Specialist Medicine’ directorates across the whole trust.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 4</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>239</td>
<td>288</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>210</td>
<td>289</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met target for Safeguarding Adults Level 4 but not for Safeguarding Adults Level 2 or Safeguarding Children Level 2.

A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for nursing staff is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>589</td>
<td>603</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>506</td>
<td>530</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>149</td>
<td>161</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>57</td>
<td>88</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

After our inspection we asked the trust for more up to date figures. These demonstrated variable progress in the completion of safeguarding training and a significant deterioration in the completion of safeguarding adults level 3 training. As of February 2018 safeguarding training completion rates per division were:

- **Acute medicine:**
  - Safeguarding adults level 1: 98%
  - Safeguarding adults level 2: 97%
  - Safeguarding adults level 3: 34%
  - Safeguarding adults level 4: 100%

- **Specialist medicine:**
  - Safeguarding adults level 1: 100%
  - Safeguarding adults level 2: 96%
  - Safeguarding adults level 3: 43%

A dedicated safeguarding lead was based in the hospital and provided as-needed support to patients and staff. Contact details for this member of staff were readily available on each ward and they assisted staff with safeguarding referrals and patient assessments. They also provided oversight for temporary staff such as locum doctors and agency nurses where they needed support with local procedures.

We saw staff had a particular focus on safeguarding in the care of the elderly wards and the elders receiving unit (ERU). For example, clinical staff worked with the safeguarding lead, social workers, carers, and community services to ensure patients received appropriate care in the hospital and when they were discharged.
Ward-based staff completed the national workshop to raise awareness of Prevent (WRAP) training, which equipped staff to recognise warning signs of radicalisation.

Staff clearly understood the differences between pressure sores and low skin integrity developed because of medical conditions, and when this might indicate neglect. For example, ward-based staff had developed a transfer checklist for patients being transferred from the receiving units to an inpatient ward that helped them identify where a pressure sore occurred. Where this was thought to have occurred in the community but not reported or where it was unexplained, staff raised a safeguarding alert.

Staff in the sexual health and contraception service used established safeguarding assessments for young people who attended the clinic. For example, for teenagers under the age of 18 staff carried out a safeguarding assessment to identify patients at risk of exploitation or bullying, particularly in relation to trends in ‘sexting’ and pornography or those at risk of female genital mutilation.

Staff used a policy that meant they would only see young people alone until they established the reason for their attendance. This was a strategy to ensure young patients had a safe space to discuss their needs away from the risk of influence or coercion.

All staff in this unit were trained to make direct safeguarding referrals to the local authority and staff completed a safeguarding review for all patients under the age of 16 at least annually. We looked at a sample of safeguarding documentation for young people and saw it incorporated structured assessments under the Fraser guidelines and the Gillick competencies. The trust’s young person lead had worked with the sexual health team to establish this documentation.

Between February 2017 and January 2018, staff in care of the elderly services reported three incidents relating to safeguarding. This represented 0.2% of all recorded incidents for the service. During the same period staff in specialist medicine reported six incidents, which was 0.2% of the total reported. The trust supplied these figures for this service but across both hospital sites. Reporting figures for safeguarding incidents were very low and the divisional board highlighted that staff did not consistently use reporting systems in relation to this. This was highlighted as an area for immediate improvement in December 2017.

**Cleanliness, infection control and hygiene**

Between February 2017 and January 2018, staff in care of the elderly services reported six incidents relating to infection prevention and control. This represented 0.3% of all recorded incidents for the service. During the same period staff in specialist medicine reported 38 incidents, which was 1.5% of the total reported. The trust supplied these figures for this service but across both hospital sites.

All clinical areas were stocked with alcohol hand gel dispensers and hand washing sinks with liquid soap and skin lotion. Each bed bay had wall-mounted stocks of personal protective equipment (PPE) such as disposable gloves and aprons. In addition, large displays had been erected at the entrance to each inpatient ward instructing visitors to use the hand-washing sinks on entry and exit to protect patients from infection. Enforcement of this was variable but where staff observed visitors entering the ward they were proactive in ensuring people washed their hands.

All handwashing sinks had posters above them to demonstrate the World Health Organisation (WHO) hand washing standards.
We reviewed cleaning schedules and the cleaning dashboard for the two months leading to our inspection with cleaning staff and supervisors. We found cleaning and infection control standards were compliant with the National Patient Safety Agency national standards of cleanliness.

Staff stored, used, and disposed of chemicals in line with the Control of Substance Hazardous to Health Regulations (COSHH) (2002). This meant chemicals were stored safely and securely with restricted access and appropriate, up to date risk assessments were in place. All staff who worked with COSHH substances we spoke with demonstrated good knowledge of safe handling procedures.

Sinks in all of the clinical areas we inspected were compliant with Department of Health (DH) Health Building Note (HBN) 00/09 in relation to the absence of plugs and an overflow system for water hygiene and safety.

Each inpatient ward monitored rates of hospital-acquired meticillin-resistant Staphylococcus aureus (MRSA). This information was displayed publically and staff used it to acknowledge positive achievement. For example, there had been no cases of hospital-acquired MRSA on Bluebell A and B wards for over two years and the ERU team noted 145 days since the last case of MRSA.

Clinical staff were expected to adhere to the aseptic non touch technique (ANTT) when performing tasks such as taking blood cultures. We saw this was commonly used in all of our observations. Practice development nurses carried out competency assessments with doctors, who were required to successfully pass this before they could use ANTT.

Practice development nurses (PDNs) had developed a ‘red card’ scheme to highlight poor infection control practice. This scheme was introduced following an external audit that highlighted inconsistent hand hygiene and infection control. A PDN or senior nurse could issue a ‘red card’ to a member of staff who was non-compliant with hospital standards of infection control. This meant they were referred to the infection control team for refresher training followed by a meeting with the medical director if practice did not improve.

Each inpatient ward and clinical area had side rooms suitable for delivering care to patients who presented with risk of cross-infection. We saw in all cases staff displayed correct signage relating to the specific precautions that needed to be taken. Although we saw widespread adherence to barrier nursing and enhanced infection control procedures for patients in side rooms, it was not evident student nurses were always supervised. For example, we saw one student nurse provide care to a highly infectious patient without washing their hands before or afterwards and without being challenged by nurses on the ward. We raised this with the nurse in charge at the time of our inspection, who said the student nurse had received an appropriate induction and they would review infection control processes with them.

We reviewed the cleaning audit process with supervisors from the cleaning contractor. We saw the audits took place within a framework than escalated to a supervisor if a cleaning order scored less than 94% compliance against agreed standards. Cleaning staff used a live, electronic recording system to document cleaning standards and checklists and worked with the ward manager in each area to ensure the audit met trust standards and local ward needs.

A lead for infection control carried out a monthly audit in each clinical ward. This included observational and practice-based checks of hand hygiene and the use of personal protective equipment (PPE). In January 2018 medical wards achieved 98% overall compliance with trust standards. This reflected 100% in the use of isolation protection standards, 98% in the use of PPE and 97% overall hand hygiene.
Environment and equipment

Staff completed online training in the principles of fire safety and the trust’s fire safety team supplemented this with practical and simulated training. However, there were wide variations in staff understanding of this. For example, staff on Harvest A demonstrated a clear understanding of fire procedures and explained their various responsibilities. They also said practical fire training had been useful in putting their theory training into practice. Staff we spoke with on coronary care unit (CCU) were less clear of their role in an emergency and one nurse said, “I haven’t seen the fire safety team here for a long time. I think we’re well overdue a refresher.” The fire safety advisor carried out a risk assessment annually in each ward and clinical area. We looked at the most recent risk assessments for Bluebell A and B wards and Mandarin A and B wards. Although moderate risks to safety were identified in October 2017 and January 2018 there was no documented evidence of the action taken or responsible person for these.

Staff in some areas described difficulty in getting support for electronic equipment problems relating to the patient monitoring system. For example, staff in the CCU said the system that monitored patients for deterioration depended on the Wi-Fi system. However, in that part of the building Wi-Fi was unreliable and staff said they had to depend on manual back-up systems as they found it challenging to get IT support. This meant they were not always sure the electronic system displayed the most up to date patient observation data.

We checked the safety equipment such as resuscitation trollies, oxygen bottles, and adrenaline resuscitation kits in all of the clinical areas we visited. In all areas we found equipment and single-use items to be within their expiry date and fully stocked. We looked at the daily and weekly safety documentation for this equipment for the two months leading to our inspection. We found staff documented checks consistently and took corrective action when equipment failed or was missing. However, junior doctors told us they often found resuscitation trollies to be understocked on medical wards, which meant they could not always find blood culture bottles or cannulas.

We found large amounts of unsecured oxygen cylinders stored around the hospital. This included ten cylinders in the ERU, three cylinders in the medical assessment unit (MAU) and six cylinders in a corridor between Bluebell wards. In each case we escalated this to a member of staff who arranged for the oxygen to be removed or secured. However we found the trust was already aware of the risk presented by this issue through fire risk assessments. The fire safety advisor identified the storage of unsecured oxygen cylinders as a moderate risk in the January 2018 risk assessment for Bluebell A and B wards although there was no documented evidence of immediate corrective action.

Inpatient wards were fully compliant with DH HBN 00/10 in relation to seamless flooring that prevented the build-up of bacteria.

All medical care wards and departments were compliant with DH HTM 07/01 in relation to the safe management and disposal of healthcare waste. This included the correct labelling and storage of sharps bins. In addition, all wards had embedded a safer needle range and needleless system that complied with EU Directive 2010/32/EU Prevention from Sharps Injuries in the Hospital and Healthcare Setting 2010.

A decontamination action group met monthly and reviewed risks and challenges to clinical environments and equipment. We looked at the minutes of meetings held between October 2017 and December 2017 and found the group was responsive and proactive in improving decontamination practice. For example an equipment audit in the endoscopy unit had identified staff could not fully prepare equipment because of removable stickers attached to them. The group identified an action plan and re-audit process to ensure this was addressed quickly. The group had
also identified areas for improvement in the management of bed frame and mattress decontamination, including in ensuring the transportation of mattresses protected people from the risk of infection.

A responsible person in each area of service completed an annual health and safety risk assessment. They carried this out using national compliance standards from the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The risk assessments included scope for improvement plans. For example the discharge lounge was sometimes used as an escalation area overnight during times the hospital was operating at full inpatient capacity. Lead staff in this area identified that operational policies were not sufficient to ensure safe continuous operation of the lounge and so developed a more specific standard operating procedure.

Assessing and responding to patient risk

A summary of the number of bed moves per patient at the King George Hospital and Queen’s Hospital sites is below. The proportion of patients moving at least once increased at both sites over the two years, from 7% to 19% at King George Hospital and from 8% to 11% at Queen’s Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of moves</th>
<th>October 2015 to September 2016</th>
<th>October 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients (%)</td>
<td>Number of patients (%)</td>
<td>Number of patients (%)</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>0</td>
<td>2,638 93%</td>
<td>1,887 80%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>201 7%</td>
<td>454 19%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6 0%</td>
<td>7 0%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,845 100%</td>
<td>2,348 100%</td>
</tr>
<tr>
<td>Queen’s Hospital</td>
<td>0</td>
<td>9,624 92%</td>
<td>8,840 89%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>871 8%</td>
<td>1,105 11%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>22 0%</td>
<td>26 0%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0 0%</td>
<td>1 0%</td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10,517 100%</td>
<td>9,972 100%</td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Request – Ward moves tab)

Between April 2017 and January 2018 43% (2936 instances) of patient moves were between the hours of 8pm and 8am. This means the moves occurred out of hours, which is associated with increased risk. This was an average figure and represented broad variances between wards. For example on the CCU out of hours bed moves accounted for 15% of the total and on Mandarin B ward out of hours moves accounted for 60% of the total.

Nurses used an electronic monitoring system that alerted them when patients were deteriorating. This system assessed clinical observations of each patient to identify signs of deterioration using the national early warning scores (NEWS) system. The system automatically alerted clinicians when a NEWS score reached a threshold, which helped ensure a timely response. Nurses
proactively contacted clinicians where they noted an increasing risk score and were also trained to manually calculate scores. This meant there was always a manual check of NEWS scores and a backup if the electronic system failed.

The trust monitored the use of NEWS on a monthly basis in each clinic area. The audit established compliance with six key performance criteria including correct calculation of NEWS, clearly defined frequency of observations and appropriate, timely escalation. Between October 2017 and January 2018 overall compliance was 97%. This was an average figure and reflected a wide range of results for individual wards from 73% in Clementine B ward in November 2017 to 100% in 13 out of 16 wards in January 2018. In this period the ERU, Sunrise B ward, the CCU, the HASU and Sahara A ward consistently scored 100%.

A PDN had implemented a training project that involved healthcare assistants (HCAs) more closely in the use of NEWS and the electronic monitoring system. For example, HCAs were trained to recognise the initial signs of deterioration as well as escalation pathways.

The PDN based on Bluebell A and B wards carried out monthly quality and safety audits on the documentation for risk assessments and patient observations. This included nursing assessments, MRSA documentation and the consistency of venous thromboembolism (VTE) assessments. In addition the trust carried out VTE audits to establish practice against expected standards such as documenting a VTE risk assessment within 24 hours of admission. Between July 2017 and January 2018 overall compliance with trust standards was 93%.

Where patients were cared for with a tracheostomy in situ, nurse staffing levels were increased to reflect the change in patient needs.

Staff used a cohort system on Bluebell A and B wards to care for patients more safely. This meant patients with similar needs were cared for in the same bed bay. For example, staff accommodated patients with a tracheostomy or at high risk of falls in the same bed bay. This enabled the nurse responsible for the bay to deliver consistent care for those with high levels of need.

The departure lounge had been open continuously since November 2017 to accommodate patients overnight as part of the trust’s bed contingency plan. To manage patient risk, escalation pathways were in place and a staff nurse and two healthcare assistants were based in the unit at all times.

Staff in the ERU used a risk management policy that meant they would not discharge a patient home after 5pm if they were unaccompanied. This reduced the risk of unplanned readmissions due to injury or a patient’s social circumstances.

The trust had improved the provision of resuscitation training for ward-based staff through scenario-based simulation training. Training teams delivered this training on each ward so that staff could familiarise themselves with the equipment and logistics of their usual work area in an emergency.

There had been previous incidents of sepsis and the trust had been identified as an outlier by CQC, and had since taken steps to address this. A sepsis link nurse was in post who provided support to ward-based teams in the treatment of patients and delivered specialist training to nurses and doctors. In addition, clinical staff in medical specialties completed tier 2 sepsis
training and a new sepsis pathway had been introduced based on national Sepsis 6 best practice. Tier 2 sepsis training refers to an advanced level of training that can be delivered to staff who have not delivered care compliant with established standards. The trust had experienced difficulty in facilitating access to practical sepsis training for staff, with 69% compliance as of November 2017. In addition locum doctors did not have access to trust sepsis training and a December 2017 divisional meeting highlighted that there was uncertainty around whether agencies supplied details of previous sepsis training to the trust.

Staff on each ward and in each clinical department held a safety huddle at least once daily and up to four times daily in some wards. Teams used this to discuss individual patients who were deteriorating or who had complex needs as well as recent incidents or complaints that affected service and care. Staff also used safety huddles to identify potential risks such as delayed discharges or problems with staffing and equipment.

A nutrition support lead, a falls lead and a sepsis lead formed a safeguarding and harm-free care group. This team worked across medical inpatient wards and provided ad-hoc training and guidance. In addition, care of the elderly services had recruited a senior nurse harm-free champion to deliver ongoing improvements to patient safety.

Each ward carried out a monthly quality of care nursing audit to establish standards of practice against eight key criteria. This included the completion of a falls risk assessment and up to date blood pressure measurements in both a standing and a lying state.

**Nurse staffing**

The trust reported their staffing numbers for nursing staff as at 31 September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>701.85</td>
<td>504.44</td>
<td>72%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

This represented a vacancy rate of 28%, which was 4% higher than our last inspection in March 2017.

We obtained information on vacancies during our inspection from ward staff, which showed vacancy rates varied between wards. For example, there were nine full time vacancies for band five nurses on Bluebell A ward. This presented a high level of risk and as such the senior team had entered this on the divisional risk register for monitoring and action. We asked nurses and senior nurses in every area we visited about staffing levels and received variable responses. On wards with high numbers of vacancies, particularly Mandarin A ward and the CCU, staff said they felt patient safety was often compromised. On one day of our inspection in the ERU three planned staff nurses were unavailable and the senior nurse was trying to secure agency nurses. On the same day in the CCU an agency nurse had been booked but did not turn up for their shift. Nurses told us it was commonplace for booked agency staff to not turn up to shifts, but they were not aware of a system in place to address this. The MAU had 13 vacant posts for band 5 nurses.
and Mandarin A ward had 10 band 5 nurse vacancies. Wards with significant numbers of vacancies were not always able to provide appropriate levels of supervision to student nurses. For example student nurses who had completed placements on Mandarin A ward told us there were specific challenges with the quality of supervision and support from the leadership team on that ward.

Ward teams were empowered to take action to reduce the risks caused by short staffing, such as by restructuring the existing team. For example, the senior team on Bluebell A and B wards had restructured the nursing team to double the number of band six nurses, from four to eight, and had created a post for a band seven acute care respiratory nurse. This individual carried out training, teaching and mentoring according to a framework based on the buddy system. The ward team had also reviewed the nursing establishment for bedside care, which had increased the number of registered nurses per shift. This meant patient risk was minimised and reflected significant adaptability by the ward team to address ongoing staffing issues.

The trust had invested significant resources to improve nurse recruitment and retention. This included a rolling programme of recruitment advertising and targeted recruitment events. Senior nurses who had left the ward due to retirement or moving trusts were invited to return in a targeted role to provide one-to-one clinical supervision and support to new nurses. Nurses who returned through this scheme completed refresher training and enabled new nurses to have a confidential and supportive point of contact whilst reducing demand and pressure on the nurse in charge of each shift.

From October 2016 to September 2017, the Queens hospital reported a sickness rate of 4% in medical care for nursing staff. This did not meet the trust's target of 2.8%. We asked senior nurses and clinical leads about nurse staffing sickness rates. They felt this was reflective of the continuing pressure on staff from shortages and working above capacity.

From October 2016 to September 2017, the trust reported that 60% of shifts within medical care were covered by bank and agency staff. Breakdowns by site were not provided by the trust.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

After our inspection the trust told us nursing sifting covered by agency and bank staff were between 20% - 60%.

Nursing teams were supplemented with clinical trainees in some areas; including 12 nursing associates across acute medicine. For example, four nursing associates were in post on Bluebell A and B wards and would undergo a final interview before establishing themselves permanently in post. A nursing intern post had also been created on this ward to support the senior team with nurse support and retention.

Student nurses worked across the hospital and each ward developed their own support and development structures for them. For example a nurse in the CCU had completed a mentorship course specifically for student nurses and provided dedicated support in liaison with their university tutors.

There were 11 physiotherapist and occupational therapist vacancies in the allied health professional team assigned to acute and specialty medicine, out of 34 total posts, representing a vacancy rate of 32%. Six therapists provided care on Sunrise A and B wards to elderly patients.
Medical staffing

The trust reported their staffing numbers for medical staff as at September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>306.85</td>
<td>248.00</td>
<td>81%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a turnover rate for medical staff of 1.0% in medicine, which met the trust target of 13%. Overall turnover rates for all core services at the trust for medical staff were 1.2%. A breakdown by site of turnover in medicine of medical staff is below:

- King George Hospital: 0.8%
- Queen’s Hospital: No medical staff were assigned to this site for medicine on the trust HR system.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Although data from the trust regarding turnover rates was limited and indicated low levels of turnover, staff in some areas said they felt turnover rates were high and had an impact on patient safety. For example, consultants told us 27 of their colleagues had left in the previous three years and more than 50% of care of the elderly and acute medicine consultant posts were filled with locum doctors.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, the trust reported a sickness rate of 1% in medical care for medical staff. This met the trust’s target of 2.8%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust report that 86.5% of shifts within medical care between October 2016 and September 2017 were covered by bank or locum colleagues.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

After our inspection the trust told us the use of locum or agency doctors varied from 18% - 87% during this period.

In August 2017, the proportion of consultant staff reported to be working at the trust was similar to the average for England and the proportion of junior (foundation year 1-2) staff was higher.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>34%</td>
<td>23%</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


Stroke services were fully staffed with eight consultants, five SHOs and four specialist registrars who maintained a 24-hour presence on the hyper-acute stroke unit and acute stroke ward.

Two consultants led care on the ERU and two consultants led care on the MAU. Where patients had been identified as medical and were waiting in the emergency department, the MAU consultant initiated care and treatment there whilst awaiting space. This meant patients received continuous consultant-led care. However staffing levels of junior doctors in the MAU were consistently low with cover provided by one registrar and two locum middle grade doctors in addition to foundation level and core medical trainees. In addition, there was not a reciprocal agreement in place for consultants on the ERU to review elderly patients awaiting admission. All patients admitted to the MAU were reviewed by a consultant within 12 hours.

Eight consultant cardiologists led care in the CCUs across both hospitals in the trust and five specialist registrars covered the service while covering medical on-call and referral responsibilities. Foundation year level one doctors carried out referrals, transfers, blood work, and discharges in the CCU. Consultants said they had escalated the risk of very junior doctors carrying out highly responsible tasks to the senior trust team but this had not been addressed. Although two SHOs were always assigned to the CCU they were also on call for other medical specialties. In addition,
clinicians told us there was consistent short staffing in the CCU. For example, the acute medicine team covered this unit and should have had one SHO, one consultant and three to four registrars overnight. However, on one morning of our inspection staff told us they had a “fraught” night because there had only been one doctor on shift. This meant they could only see the highest risk patients. Senior clinical staff we spoke with confirmed this against the rota although this was not reflected in the service risk register.

Nine out of 10 risks on the specialist medicine risk register rated as ‘high’ related to risks to clinical safety or service provision due to a lack of clinical staff. This included nursing vacancies on Mandarin A ward and Clementine B ward and a lack of medical staff in gastroenterology, hepatology, neurosciences, cardiology, rheumatology and respiratory services. There was a lack of evidence that risks were regularly updated and no consistent, robust or adequate control measures in place. On the care of the elderly risk register a lack of nurse staffing was listed as an extreme risk and this accounted for three out of four high –level risks.

**Records**

Patient records were a mix of electronic assessments and observations and paper-based bedside and multidisciplinary notes. We looked at a sample of 29 patient records across all areas we visited and found them to be consistently completed. This included with the name and role of staff adding notes, the time of each entry and legible information.

The respiratory team were research active and had completed two projects aimed at improving documentation and patient records. For example, one project resulted in an improvement in the recording of antibiotics that led to an omission rate of less than 2%. The project also resulted in a 37% improvement in the documentation of oxygen saturation on nursing charts, from 53% to 90%. Another project resulted in an improvement in the documentation of antimicrobial reviews from 37% to 100% by the end of the study.

The sexual health and contraception team were trialling a new patient records system for young people who accessed multiple services. This would enable the team to share patient information in advance, with consent, with other sexual health clinics so that patient care would be coordinated.

Consultants could track their patients wherever they were in the hospital through the electronic monitoring system. This meant each patient’s consultant or responsible doctor was aware of a change in condition or deterioration.

The hospital had introduced an electronic tracking system for medical records. This helped clinical staff to locate medical notes where they had been stored in different formats and locations, which helped to reduce the time spent on administrative tasks.

Staff from each ward audited a sample of patient notes on a monthly basis that established standards against 10 key criteria, such as if an essential nursing booklet had been completed and if staff had updated changes to each patients’ needs. Between June 2017 and January 2018 overall compliance was 90%. This was an average figure across medical inpatient wards in both the acute and specialist medicine divisions and reflected highly variable monthly performance between a range of 54% in the MRU in June 2017 to frequent instances of 100%. There was evidence the audits resulted in improved practice in some areas. For example following variable performance, the HASU achieved 100% continuously between November 2017 and February 2018. However some wards performed consistently poorly in the completion of patient transfer checklists. In the above period only 17% of checklists were completed fully and correctly on
Bluebell A and B wards. During the same period most wards performed variably in this measure including 23 instances of 0% compliance.

**Medicines**

Each ward had a named pharmacist assigned to it and a pharmacy technician based on the ward. This meant each ward had dedicated support for discharge medicines, medication counselling and reviews of medicine errors. Pharmacists and technicians attended business meetings for their clinical area to provide safety oversight or issues and incidents. The pharmacy team carried out a weekly audit on medicines management and led stock management in each area.

Senior nurses and pharmacists used an established system to investigation medication errors. This involved a review of the whole multifactorial cycle such as who prescribed the medicine, when and why. They used this information to identify why the error had not been predicted or avoided and to implement processes that would help avoid a recurrence.

An antibiotic stewardship programme was in place in the respiratory wards to ensure patients were transitioned from oral medication to intravenous medication on time.

All of the nurses in the sexual health and contraception service were prescribers and could administer medicines against specific patient group directions (PGDs). We saw all of the PGDs in the clinic were up to date and had been regularly reviewed. The team attended an annual medicines update day with the pharmacy team, who also provided support for PGDs and staff competencies.

We observed staff adhered to good medicines safety practices during our observations of medication rounds on wards. For example, staff checked each patient’s allergies and their identity name band before starting administration. We saw nurses observed the trust policy when a patient refused their medicine, including escalating this to the patient’s doctor and the nurse in charge.

Nurses in each ward or clinical area understood the most common medicine errors in their area of work and the strategies to avoid these. For example, in the ERU nurses said prescribers did not always document the route of administration for medicines, which caused delays.

Pharmacists carried out daily rounds in the ERU and MAU to ensure medicines management processes, including for controlled drugs, were used safely and in line with trust policy.

Staff routinely checked and documented the temperature of fridges used to stored medicine. We looked at the documents for ERU and saw three daily checks were missing between December 2017 and January 2018. In addition, the unit did not monitor the temperature of the medicine storage room. This meant they could not be assured medicines were stored within the safe temperature range set by pharmaceutical manufacturers.

We found evidence of learning and improved processes from medicine errors. For example, an incident relating to a missing CD was raised in the MAU. The medicine was found incorrectly stored in another cupboard and as a result new security processes were introduced. This included one person per shift holding accountability for CDs and clearer documentation of patients who were being discharged with CDs.

We looked at controlled drug (CD) storage in all medical care wards and departments. In the majority of areas we found consistent, accurate CD documentation that matched stock levels. In the endoscopy unit we found a discrepancy between the documented stock and actual stock of one CD. We spoke with a nurse about this who identified why the error had occurred and corrected it. A pharmacist checked CDs in this unit twice daily as part of the safety process.
We found a liquid CD had been pre-prepared in the endoscopy unit ready for the next clinic, which was not in line with trust policy.

The divisional nurse for anaesthetics acted as the hospital’s dedicated medicines error lead. The lead worked with pharmacy colleagues and PDNs to support staff involved in medicines errors and prepare action plans and medication workbooks for staff involved in incidents.

Chemotherapy medicines were prescribed electronically in line with national guidance. Doctors had to be at registrar level or above to prescribe chemotherapy.

In one ward we found five fridge temperatures had been recorded out of the safe range five times within a nine day period. Staff had taken precautions, contacted the appropriate people for advice and ensured that all staff were made aware during handover meetings of the fridge problem.

We saw that lactulose, a liquid medicine, had been poured down the sink in a clinical treatment room and not disposed of appropriately. This had caused the sink to block and the maintenance team had to be called. We spoke with the nurse in charge who said this was not usual practice and they would address it.

Between February 2017 and January 2018, staff in care of the elderly services reported 171 incidents relating to medication. This represented 10% of all recorded incidents for the service. During the same period staff in specialist medicine reported 292 medicine incidents, which was 12% of the total reported. The trust supplied these figures for this service but across both hospital sites.

Pharmacy and ward staff carried out monthly audits of CDs and medicine management in the MRU and ERU. We looked at a sample of audits from October 2017 and December 2017. Overall medicine security and governance standards were variable and audits identified a need for improved control of CD access as an area for improvement. In additional a medicines improvement ‘walkabout’ in October 2017 in the MRU identified that medicines belonging to patients no longer in the unit were still stored in a fridge and that no action had been taken on three occasions with a medicines fridge temperature had exceeded the safe range. In addition the audit found unlabelled antibiotics in the fridge and medicine with conflicting labelling.

A 2017 audit of contraception prescribing and the safe use of PGDs in the sexual health service found 89% compliance. Areas for improvement included more consistent documentation of patient history and recording of NMC/GMC numbers. The audit also found one instance of unsafe prescribing, which the senior time addressed through the drug error policy. There was also a need for improved documentation of the advice staff gave to patients. The audit team worked with senior nurses to implement recommendations for improvement and planned to reaudit this in 2018 to identify if improvements had been made.

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 November 2016 to October 2017, the trust reported one incident classified as a never event for medicine. This was the failure to remove a guidewire used for a chest drain. This incident occurred at Queen’s Hospital, Romford on 17 November 2017 (reference 2017/17910/RF4).
Staff demonstrated good knowledge of the never event root cause analysis, outcomes and learning from this. For example, a PDN told us the trust had been open with communication as the investigation progressed. As a result of the outcome, procedures regarding chest drains were changed to ensure the treating doctor always had a named assistant with whom they established a plan that included pain management and completion of the World Health Organisation surgical safety checklist.

In accordance with the Serious Incident Framework 2015, the trust reported 49 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017. This table lists the types of incident in each location and a total.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>King George Hospital</th>
<th>Queen's Hospital</th>
<th>Location not specified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI/Infection control incident</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>8</td>
<td>18</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Treatment delay</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>18</strong></td>
<td><strong>29</strong></td>
<td><strong>2</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

Staff demonstrated knowledge of learning from incidents and serious incidents. All of the clinical staff we spoke with were able to discuss changes in practice or policy as a result of incident investigations. For example, following a missed diagnosis from a diagnostic imaging test, a new flagging protocol was implemented to improve communication of results between clinicians. Another incident related to a grade four pressure ulcer that developed undetected because the patient had been fitted with a plaster cast. As a result staff introduced new plaster care pathways based on holistic care, which improved regular monitoring. The root cause analysis of this incident identified that nurses rarely came across plaster care. To address this, plaster technicians launched a training programme to support ward-based nurses. Staff shared learning and outcomes from such initiatives through the monthly patient safety summit, which was a strategy to embed quality improvement and clinical developments across all teams.

A clinical nurse specialist for geriatrics completed a weekly surveillance audit of incidents to identify themes and areas they could implement immediate remedies.

To improve the range of staff who could carry out investigations following an incident, PDNs were training band six nurses in root cause analysis theory and practice. This included practical training in reviewing previous incidents.

Matrons and PDNs told us they had prioritised changing the reporting culture from a blame culture to one of safety improvement. This meant they encouraged staff to report mistakes so that the whole team could explore how they happened, as opposed to a punishment or reprisal. This was
reflected in our conversations with staff; all of whom said they felt confident and empowered to report an incident as well as poor practice.

Between February 2017 and January 2018 staff in care of the elderly medical services reported 1879 incidents and staff in specialist medicine reported 2454 incidents. Of these 45% related to tissue viability and 18% related to falls. This was reflected in the conversations we had with clinical staff in care of the elderly services who demonstrated a proactive approach to reducing incidents of these types. During the same period staff in specialist medicine reported 2454 incidents. Of these 21% related to falls and 12% related to tissue viability. The trust supplied these figures for this service but across both hospital sites.

The trust categorised incidents by the level of harm to patients or staff. Between October 2017 and January 2018 in specialist medicine 63% of incidents resulted in no harm and 4% were reported as a near miss. In addition 29% of incidents related in low or minimal harm, 2% resulted in moderate harm and 0.7%, or four incidents, resulted in death.

Senior clinicians and risk and governance teams including morbidity and mortality (M&M) discussions in cross-site specialty meetings. For example the cardiology and renal teams discussed M&M within monthly quality and safety meetings. We looked at a sample of 12 M&M meeting minutes and presentations between July 2017 and January 2018. M&M meetings in cardiology were consistently well attended by a substantial range of staff including consultants, cardiologists, foundation level doctors, nurses and clinical nurse specialists, cardiac physiologists and the quality and safety team. We saw evidence in this service staff discussed a sample of M&M cases as part of a multidisciplinary approach with a focus on identifying opportunities for learning. For example one patient review identified concerns with a transfer between wards that resulted in a failure to rescue and a subsequent serious incident report. The team used M&M learning to acknowledge good practice and to highlight were different action may have improved patient outcome as part of a culture of learning.

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 suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 35 new pressure ulcers, 25 falls with harm and one new catheter urinary tract infection from November 2016 to November 2017 for medical services. Pressure ulcer rates fluctuated over the year but with higher numbers in the second half of the year. Rates of falls fell to nothing between April 2017 and October 2017 and the one catheter associated urinary tract infection (C.UTI) reported was in December 2016.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barking, Havering and Redbridge University Hospitals NHS Trust
Divisional teams tracked safety thermometer performance on a monthly basis to identify trends and changes in performance. Performance was variable although monitoring included pressure ulcers that had been acquired in the community prior to a patient’s admission. Between July 2017 and January 2018 Sunrise A and Bluebell A wards maintained a trend of overall improvement whilst Sahara A and B wards and the hyper acute stroke unit maintained steady performance. Performance on Harvest A ward and the MRU deteriorated during the same period.

As part of a drive to improve skin and tissue viability care, eliminate hospital-acquired pressure ulcers (HAPU) and reduce falls, each ward team had established their own initiative. Staff prepared up to date information displays based on their performance and placed these in prominent areas. All of the staff we spoke with were enthusiastic about this initiative and were demonstrably proud of their track record. For example, Bluebell B ward was celebrating 338 days without a HAPU, the ERU team was celebrating 143 days and the Bluebell A team was celebrating 130 days without a HAPU following a change in how they delivered bedside care. Although the CCU had a similar display, the team did not display its track record on safety.

The practice development nurse responsible for care of the elderly had worked with ward staff to introduce advanced training in falls prevention. In addition, patients at high risk of falls were treated in the same bed bays (a cohort system) so that nurses could provide more targeted monitoring. As a result of the initiatives the ward had achieved 97 days without a fall. The teams on these wards used four times daily safety huddles to identify which patients had been turned in line with the pressure ulcer prevention programme. Where patients had not been turned the nurse in charge identified what contributed to this, such as short staffing, and implemented a recovery plan immediately. The hospital falls team provided fall sensors for patients at high risk and following appropriate consent or mental capacity assessment.

Between February 2017 and January 2018 39% of reported incidents in medical care services related to falls and 57% related to tissue viability. The trust supplied these figures for this service but across both hospital sites. The trust participated in the 2017 national inpatient falls audit to monitor risk screening, prevention and reporting. This highlighted that the trust did not use a
standard falls risk screening tool, which was in line with NICE clinical guidance 161. The trust had a multidisciplinary falls prevention working group that met quarterly and discussed falls incidents at ward and directorate level and used a multifactorial risk assessment for each patient. In addition the hospital performed well in the audit for the use of appropriate care planning and documentation. For example 100% of patients had a continence or toileting care plan, 100% of patients had a mobility care plan, 93% of patient records included documentation of their level of mobility and 84% included a record of their fear of falling.

Is the service effective?

Evidence-based care and treatment

The specialist medicine divisional board monitored compliance with national guidance from the National Institute for Health and Care Excellence (NICE). This measured trust policies and clinical standards against 106 NICE national guidance standards, Between July 2017 and December 2017 average compliance was 69%, ranging from 56% in August 2017 to 72% in December 2017.

In 2016/17 staff registered 123 audits in specialist medicine services. Each specialty service had a clinical audit lead that monitored progress and outcomes through specialty quality and safety meetings. This included both national and local audits and the National Clinical Audit and Patient Outcomes Programme Healthcare Quality Improvement Partnership (HQIP). The minutes of governance meetings indicated staff tracked the progress of audits and between December 2017 and January 2018 16 out of 17 HQIP audits were rated as ‘red’, which meant they were not on track for expected completion. One HQIP audit, the fracture liaison database, was on track for expected completion. It was not evident from meeting minutes why audits were delayed with the exception of the national diabetes audit, which could not be completed because there was not a podiatry team in post.

The endoscopy team planned five accreditation audits in 2017/18 as part of ongoing Joint Advisory Group accreditation, including a patient satisfaction project that was already in progress and had contributed to improvements. Across specialty services 26 audits related to quality improvement and benchmarking and 53 related to assurance against national and international standards. Overall the audit programme demonstrated a continuous drive by specialty teams to ensure care and treatment was evidence-based against the latest practice standards.

Some ward teams were participating in research based on the national work carried out under the NHS England releasing time to care – the productive ward programme. As part of this they had adapted key elements to the needs of their patients. For example, the team on Harvest A ward had implemented a five step process for equipment to ensure essential items for care were always readily available and accessible.

Staff in the endoscopy unit used the World Health Organisation surgical checklist for each procedure to ensure it was carried out safely and according to international guidance. This unit was Joint Advisory Group (JAG) on GI endoscopy accredited, which meant the unit had been assessed as providing patient-centred care as defined by the global rating scale.

Staff in care of the elderly services had developed a ‘productive board’ based on national and pressure ulcer best practice guidance from NHS Improvement and a national pressure ulcer collaborative. This evidence-based initiative involved nurses and healthcare assistants organised into teams on a daily basis and completing a structured red, amber, green (RAG)-based assessment of all of their patients for pressure ulcers and falls by 11am each morning. Each
team leader displayed their RAG assessments on the productive board, which was reviewed by
the nurse in charge and the practice development nurse (PDN).

The ward manager on Harvest A ward had initiated a cycle of cannula documentation and visual
infusion phlebitis (VIP) audits and had shared the outcomes and learning from these with ward
managers across medical care services.

The sexual health and contraception team was planning to join the City of London sexual health
online transformation programme to deliver improved London-wide sexual health care through
better online resources. This was an evidence-based programme and staff had identified
significant potential benefits for patients in the future.

Clinical and specialty teams discussed national policy and guidance updates as part of monthly
quality and safety meetings. This ensured updates or changes to policies were identified and
discussed in the context of patient need by staff who would deliver care.

A British HIV Association (BHIVA) clinical audit in 2017 identified variable standards of discussions
between staff and patients living with HIV with regards to the assessment of support needs. For
example 80% of patients were asked about their mental health status and psychological support
needs; 73% were asked about alcohol use and 58% were asked about their recreational drug use.
The sexual health team presented this data at a national BHIVA event as part of their strategy to
ensure sharing of good practice and areas for improvement.

**Nutrition and hydration**

Inpatient teams, with the support of dieticians and speech and language therapists, had
implemented a new standard operating procedure for mealtimes. This included a ‘before, during,
and after’ system that established standards of service, mouth cleaning and environmental
cleanliness. The whole ward team contributed to the new mealtime service, which supported the
overall understanding that if patients were well fed and hydrated their risk of falls was reduced. We
observed breakfast services on Clementine A and B wards and lunch services on Harvest A ward
and Bluebell A and B wards. Staff delivered the service according to the new standards in each
case and facilitated a sociable and lively meal that encouraged everyone to talk, interact and enjoy
their food.

Bed bays had communal tables that were installed to encourage patients to leave their bedside to
eat in a communal setting; we saw these used where patients wanted to. All staff not involved in
immediate or urgent care contributed to the meal services and catering contractor staff worked
alongside nurses and healthcare assistants to engage with patients and encourage them to eat
and drink. Although patients ordered meals in advance, in all cases staff reminded them what they
had ordered and offered additional options in case they had changed their mind or their condition
meant they needed another option.

Staff used the malnutrition universal scoring tool (MUST) to monitor each patient’s risks
associated with nutrition and hydration. We saw staff discussed MUST scores during handovers
and board rounds and were proactive in implementing interventions when patients’ needs
increased. The trust monitored compliance with MUST documentation on a monthly basis in each
ward. Between August 2017 and January 2018 overall compliance with trust standards was 86%.
This reflected a wide range of individual results from 26% in the MRU in January 2018 to
consistent performance above the 90% target on the CCU and Harvest B wards. Mandarin A and
Sahara B wards did not meet the 90% standard in any month during this period with average performance at 58% and 59%.

Patients spoke positively about the quality and choice of food. For example, one patient said “I don’t like the breakfast very much. There’s nothing wrong with it I just don’t like it. Every day one of the kitchen staff come and talk to me and they always find something else, just some tea and fruit. They’ve gone out of their way to be helpful.” Patients also said they had enough to drink and staff consistently offered water and juice.

A nutrition support team worked across medical wards and provided individual support to patients. This was targeted care for patients unable or unwilling to eat or drink due to medical conditions or mental health issues. This also carried out insertions of nasogastric tubes to support good nutrition and provided one-to-one practical training for clinical staff on managing these. The nutrition support team were also involved in patient discharge planning and liaised with patients, relatives, and social workers to ensure packages of care included appropriate nutritional guidelines.

New menus had been introduced across the hospital. These included greater choice for specialist diets, including for Kosher and vegan diets, and more snack options between meals. Staff in care of the elderly wards said the new menus were very popular with patients and with dieticians and the nutrition support team because it meant older patients who liked to eat very small meals but frequently now had the option to do so. In addition, the hot meal service had moved from a strict time schedule to a 24-hour, seven day service. This meant patients admitted overnight or at weekends were not limited in what they could order.

Speech and language therapists and dieticians had worked together to identify and introduce a new type of food and drink thickener. This was more palatable to patients and helped them to support patients with nutritional needs because they were more likely to accept this in their diet.

Each inpatient ward was fitted with a nutritional board that identified each patient’s nutrition and hydration needs. This enabled housekeepers and other ward staff to quickly identify which patients were on modified diets and who could be offered additional snacks. We saw staff used the boards consistently and ensured they were updated whenever a patient’s needs changed.

The SaLT team led a task and finish group to analyse and improve adult risk feeding in the trust and also took responsibility for the national ‘mouth care matters’ directive.

**Pain relief**

Staff adhered to the principles and guidance of the Faculty of Pain Medicine Core Standards for Pain Management (2015).

All 19 patients we asked about pain relief said they felt this was managed well and that they had not had to wait for pain medicine.

A dedicated pain team worked across both hospitals in the trust and reviewed patients with pharmacists and clinical staff on each ward. The critical care outreach team provided further support for ward-based staff in managing pain out of hours.

The relatives of patients who received end of life care said staff were proactive and consistent in providing pain relief and had shown them how to safely and effectively use syringe drivers.

Staff used the World Health Organisation analgesic ladder to assess and treat acute pain, which meant treatment was evidence-based.
Patient outcomes

From August 2016 to July 2017, patients at the trust had a risk of readmission for elective admissions which was similar to what was expected and a risk of readmission for non-elective admissions when compared to the England average which was higher than expected.

Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in Gastroenterology and Dermatology had risks of readmission for elective admissions which were similar to expected.
- Patients in Clinical Oncology (Previously Radiotherapy) had a risk of readmission for elective admissions which was higher than expected.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in General and Geriatric Medicine had risks of readmission for non-elective admissions which was higher than expected.
- Patients in Sport and Exercise Medicine had a risk of readmission for non-elective admissions which was similar to what was expected.

From August 2016 to July 2017, patients at Queen’s Hospital had a risk of readmission for elective admissions which was similar to what was expected and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top
three specialties for specific trust based on count of activity.

- Patients in Gastroenterology and Dermatology had risks of readmission for elective admissions which were similar to expected.
- Patients in Clinical Oncology (Previously Radiotherapy) had a risk of readmission for elective admissions which was higher than expected.

Non-Elective Admissions – Queen’s Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in General Medicine had a risk of readmission for non-elective admissions higher than expected.
- Patients in Geriatric Medicine had a risk of readmission for non-elective admissions higher than expected.
- Patients in Sport and Exercise Medicine had a risk of readmission for non-elective admissions similar to expected.

The readmission rate for patients undergoing unplanned endocrine treatment was 14% in 2017, which was better than the national average of 16%.

Queen’s Hospital takes part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade D in latest available audit, covering the period from April 2017 to July 2017. The hospital has scored a D in the last three audits.

Overall scores

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 ~Mar 17</th>
<th>Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>B</td>
<td>D↓↓↓</td>
<td>C↑↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>B</td>
<td>D↓↓↓</td>
<td>C↑↑</td>
<td>D↓</td>
<td>A↑↑↑↑↑</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B↓↓</td>
<td>C↓</td>
<td>B↑↑</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>B↓↓</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>

Patient and team level performance was mixed in the most recent audit with a score of E for the stroke unit and scores of A for scanning, occupational therapy and speech and language therapy in the latest audit.

Patient centred Performance

<table>
<thead>
<tr>
<th>Domain 1: Scanning</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 ~Mar 17</th>
<th>Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓↓</td>
<td>A↑</td>
<td>A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2: Stroke unit</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 ~Mar 17</th>
<th>Apr 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
<td>D↓</td>
<td>D</td>
<td>C↑</td>
<td>E↓↓↓</td>
<td>E</td>
</tr>
</tbody>
</table>
The lead stroke team attributed the decline in SSNAP grading to the closure of a neighbouring acute stroke service, which resulted in significant additional demand on the service. However, the stroke service remained consultant-led and in the 12 months leading to our inspection all patients were seen by a consultant within 14 hours of admission.

As part of our inspection we reviewed more up to date information, which related to the SSNAP from August 2017 to November 2017. In this the trust demonstrated a significant improvement, to a B score overall.

In November 2017 the stroke team carried out a thrombolysis audit to identify patients eligible for this treatment but who had not received it or received it late against NICE and Royal College of Physicians guidance. The audit resulted in an action plan that demonstrably led to improved practice. For example stroke clinicians had protected time included in their rota to provide dedicated support to SSNAP administrators for improved data entry. Also as a result of the audit a new incident reporting requirement and investigation system was implemented alongside improved training for doctors in completing risk assessments. In addition the trust received an overall B grade in the November 2017 SSNAP audit results, indicating a significant improvement in standards. This reflected a rating of 80 for team-centred key indicators and 76 for person-centred key indicators.
Results for Barking, Havering and Redbridge University Hospitals NHS Trust in the 2015/16 Heart Failure Audit were better than the England average at Queen’s Hospital for all four standards and worse than the England and Wales average for three of the four standards relating to in-hospital care.
Results for Barking, Havering and Redbridge University Hospitals NHS Trust in terms of discharge are provided in the table below.

Queen’s hospital Romford scored about the same or better than the England and Wales average for seven out of the nine standards and worse than the England and Wales average for two standards.

(Source: NICOR – Heart Failure Audit (April 2015 – March 2016))

In 2016 the heart failure nurse specialist carried out a review of audit performance to identify strategies for improved practice. This resulted in the implementation of a system that meant a consultant cardiologist was the single point of contact for patients admitted with acute heart failure. In addition the electronic records system and quality standards for discharge were updated to improve adherence to national best practice.
The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 39 inpatients with diabetes at Queen’s Hospital. This was equal to 20.5 per cent of the beds audited, which places Queen’s Hospital in Quartile 4.

In Queen’s Hospital in 2016, 77.9 per cent of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in Quartile 1. The table shows the historical overall satisfaction values, with corresponding quartiles, for Queen’s Hospital, as well as the overall England values for each of these years. This meant the hospital was in the top 25% of hospitals nationally for this patient measure.

**Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital 2010 – 2016**

<table>
<thead>
<tr>
<th>Audit year</th>
<th>Chosen site</th>
<th>Quartile</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>N/A</td>
<td>N/A</td>
<td>80.8%</td>
</tr>
<tr>
<td>2011</td>
<td>100.0%</td>
<td>Quartile 4</td>
<td>84.8%</td>
</tr>
<tr>
<td>2012</td>
<td>92.9%</td>
<td>Quartile 4</td>
<td>85.7%</td>
</tr>
<tr>
<td>2013</td>
<td>86.7%</td>
<td>Quartile 2</td>
<td>86.0%</td>
</tr>
<tr>
<td>2015*</td>
<td>79.3%</td>
<td>Quartile 1</td>
<td>84.3%</td>
</tr>
<tr>
<td>2016</td>
<td>77.9%</td>
<td>Quartile 1</td>
<td>83.7%</td>
</tr>
</tbody>
</table>

* There was no audit collection or report in 2014, so 2014 data is not available.
(Source: NHS Digital)
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 20.3% of Nstemi patients were admitted to a cardiac unit or ward and 94.5% of patients were seen by a cardiologist or member of the team compared to an England average of 96.2% and 55.8%.

The proportion of Nstemi patients who were referred for or had angiography at Queen’s Hospital was 92.9% compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>Nstemi patients seen by a cardiologist or a member of team</th>
<th>Nstemi patients admitted to cardiac unit or ward</th>
<th>Nstemi patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital</td>
<td>128</td>
<td>128</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>94.5%</td>
<td>20.3%</td>
<td>92.9%</td>
</tr>
<tr>
<td>King George Hospital</td>
<td>121</td>
<td>121</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>91.7%</td>
<td>55.4%</td>
<td>89.1%</td>
</tr>
<tr>
<td>England: overall</td>
<td>39,082</td>
<td>39,082</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

A MINAP specialist nurse was in post in the CCU and worked with cardiologists to provide specialist care for patients experiencing heart failure. This individual liaised with community nurses to plan post-discharge care for patients with long-term heart failure or treatment needs.

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 85% against a minimum standard of 90%. This reflected a significant improvement from 2016, in which 32% of patients were seen. This was also the highest result within the region for this audit and measure.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 20.4%; this is not significantly different from the national level. The 2015 figure was 27%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 61.8%, this is significantly better than the national level. The 2015 figure was 100%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 81.5%; this is not significantly different from the national level. The 2015 figure was 71%.

The one year relative survival rate for the trust in 2016 is 35.7%.

(Source: National Lung Cancer Audit)
In the 2017 National Audit of Inpatient falls the trust performed as follows:

The crude proportion of patients who had a vision assessment (if applicable) was 66%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 55%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 38%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 70%; this failed to meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust reported all falls that resulted in a hip fracture as an incident with severe harm.

We saw evidence of targeted work to reduce falls in some wards, including Bluebell A and B wards. This included improved staff training and the implementation of strategies to target the causes of falls and to protect patients from harm. However the audit data above indicated need for a significant shift in working culture in the hospital to ensure improvements were fully embedded.

The clinical team on Bluebell A and B wards demonstrated consistent focus on ensuring patients had regular chest physiotherapy. This was a strategy to ensure patients became fit and well and to reduce the focus solely on discharge. This was an embedded process and we saw therapists joined ward rounds and board rounds to ensure each patient had dedicated input and reviews.

Clinical teams were active in research to improve patient outcomes and we saw evidence this resulted in improvements in patient care. For example, a research study to improve the recording of oxygen saturation and antimicrobial prescriptions in patient records on the respiratory wards resulted in improved compliance from 46% at the beginning of the study to compliance sustained at 90% or above by the end of it. As a result of more consistent 48 hour reviews, the average time patients were prescribed antibiotics decreased from 2.6 days to 1.5 days.

A cardiac rehabilitation team led a structured follow up programme for patients after they were discharged from the CCU in line with national best practice standards identified by the British Heart Foundation National Audit of Cardiac Rehabilitation. Each patient was offered an eight week rehabilitation programme consisting of a series of structured sessions that included exercise, relaxation and multidisciplinary educational talks. In the 12 months leading to our inspection the team achieved an 89% success rate in patients completing the programme. Where patients were unable to attend scheduled classes, the rehabilitation team visited them at home to help them complete the programme.

The allied health professional team was leading the development of a single initial documentation project that would improve efficiency in gathering patient clinical history before they were admitted to a medical ward from the emergency department. This meant patients arrived on the ward or receiving unit with a discharge plan in place, which meant the clinical team did not need to spend as much time on this. It also meant patients were not asked the same questions on multiple occasions before documentation was better connected. In addition therapies teams had completed a ward-based pilot project to implement trusted assessments for patients who required further inpatient rehabilitation. The project had been successful and would be rolled out across all inpatient wards.
The therapies team led a collar and brace care pathway that meant patients received continuing care in the community instead of remaining in hospital for extended periods of time. The pathway resulted in improved training for staff and the implementation of an algorithm to support best practice whilst the patient was treated as an inpatient.

Where medical inpatients were treated as outliers in other areas of the hospital, such as on surgical wards, we found the medical team monitored their location and treatment delivery. This included consultant-led reviews and oversight led by the site team.

**Competent staff**

Due to the way data are held on their local systems, the trust was unable to provide appraisals information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘acute medicine’ and ‘specialist medicine’ directorates across the whole trust.

From April 2017 to October 2017, 86% of staff within the ‘acute medicine and ‘specialist medicine’ directorates at the trust had received an appraisal compared to a trust target of 85%. A breakdown of appraisal rates by staff group is below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of individuals trained Apr 17 to Oct 17</th>
<th>Number of individuals required – Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Scientific and Technic</td>
<td>7</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>21</td>
<td>24</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>631</td>
<td>705</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>330</td>
<td>403</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>211</td>
<td>240</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2</td>
<td>5</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1,202</strong></td>
<td><strong>1,386</strong></td>
<td><strong>86%</strong></td>
<td><strong>85%</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

In sexual health services 92% of staff had an up to date appraisal. This was an average over three staff groups in this service ranging between 83% for sexual health management to 100% for HIV medicine.
Practice development teams provided educational materials for staff on each ward. For example, a learning corner on Harvest A ward included up to date materials on diabetes, tissue viability, infection control, and nutrition to support staff to deliver care based on individual need.

A new acute care respiratory nurse had joined Bluebell A and B wards to deliver targeted bedside-based teaching and learning to the nursing team. This was in response to specific risks in this ward relating to short staffing and enabled staff nurses to develop their skills and deliver more specialised care. In addition, all agency nurses on these wards were allocated secured lines of work and completed tracheostomy training before they could work on the ward.

A PDN led the development of new training and clinical competencies for chest drain procedures. The learning programme involved mixed study groups of doctors and nurses to ensure they embedded the different roles and responsibilities in such treatment.

We asked a sample of 13 staff about their experiences with supervisions. In each case staff said they were encouraged to learn from the previous six months and identify what had worked well and what they could improve. Nurses also told us the senior staff who led supervisions supported them to establish future development plans and decide how they wanted to develop their specialist competencies.

All nurses in the CCU completed a cardiac care competency course before they could work alone with patients.

All nurses in the sexual health and contraception service had completed the British Association of Sexual Health and HIV sexually transmitted infections foundation (STIF) course.

Consultants facilitated a consistent emphasis on teaching for junior doctors and each specialist planned dedicated learning and education sessions. For example, the lead consultant for acute medicine and renal care and the lead consultant for care of the elderly ensured protected time for trainee doctors. We spoke with a trust grade doctor who said they had protected teaching time weekly and as well as a weekly radiology meeting and regular grand rounds as education opportunities. In addition, they had the opportunity for one week per year of dedicated educational development time. However, scheduled teaching dates had been cancelled for three consecutive months due to pressure on staffing levels leading to January 2018. Doctors we spoke with were not aware if there was a recovery plan in place for this.

A nurse manager and consultant led the hyper-acute stroke unit (HASU), which initiated patients on an intensive rehabilitation pathway aimed at transferring them to the acute stroke ward within three days.

PDNs worked with healthcare assistants (HCAs) who wanted to develop their clinical skills and identified developmental competency training with them as part of structured progression plans. For example, HCAs from care of the elderly services had completed echocardiogram (ECG) training with a specialist on patients in real time in outpatients.

PDNs had completed audits on each inpatient to identify if they were conducive environments for learning. They found in most cases wards facilitated good education opportunities but staff were limited because of workloads. In response PDNs established weekly protected teaching sessions with multidisciplinary colleagues, for ward nurses and HCAs.

Nurse associates were completing a structured training and development plan. This included two days per week on a ward with responsibility for patients under supervision from senior nurses and a requirement to complete competencies in nasogastric tubes, venepuncture and cannulation.
Patients with a tracheostomy were often cared for on Bluebell A ward, where 90% of nurses had specialist training. In addition, a critical care specialist nurse was based on this ward seven days a week to ensure the nursing team was supported in the delivery of care.

Agency nurses on Harvest A ward had completed competency training in tracheostomy care and routinely attended ward meetings. This was part of the ward manager’s strategy to establish a benchmark for all staff who worked on the ward.

The therapies team had established rotations for junior staff to spend time working with community, acute and social services. This was a strategy to improve patient care as well as recruitment and retention in the team.

The pharmacy team monitored data on antimicrobial stewardship and provided feedback to prescribers and team. An antimicrobial stewardship group had representation from each division and clinicians. Junior doctors undertook training in antimicrobial stewardship as part of their induction. The trust participated in the European antimicrobial awareness initiative and World Antibiotic Awareness Week in November 2017 and as part of related staff engagement exercises led by the pharmacy team, over 100 pledges for good practice were made. The pharmacy team worked with consultant microbiologists and senior medical staff to establish 10 new guidelines in 2017/18 relating to specific treatment and rewrote the antimicrobial stewardship policy. This introduced new standards for staff and ensured microbiology ward rounds occurred in line with best practice. Clinical staff were required to undertake an antimicrobial stewardship mandatory training module.

**Multidisciplinary working**

A team of physiotherapists and occupational therapists were assigned to each clinical area, including a rapid response team for the elderly receiving unit, medical receiving unit and Sunrise A ward. This team provided specialist therapy for cardiac and respiratory patients as well as those with high levels of frailty and those being treated for cancer.

A lead nurse for quality and safety had joined Bluebell A and B wards. This post was designed to provide support to existing nurses in the specialised environment and to assist with bed management and patient flow. This individual also liaised with the critical care team to ensure the ward could provide appropriate ‘step-down’ care for patients ready to leave the intensive care unit (ICU). The critical care outreach team carried out a post-discharge assessment of each patient who was stepped down to an inpatient ward.

The speech and language therapy (SaLT) team had increased their presence on inpatient medical wards as part of a programme to improve care for patients with dysphagia and chronic obstructive pulmonary disease (COPD). As part of this the SaLT team had introduced fluoroscopy procedures for patients with COPD.

A psychiatric liaison team were based on site.

The respiratory team had worked with the emergency department (ED) team to establish a transfer pathway specifically for patients who required non-invasive ventilation (NIV). This meant ED staff stabilised patients and began NIV in a dedicated bed bay before arranging a transfer to the respiratory ward. All nurses who worked on the respiratory ward completed practical competency training in caring for patients with NIV in place.

Although staff in the respiratory wards had access to screening for tuberculosis and HIV in patients whose immune system was compromised, it was not evident there were established
pathways or available specialists for all patients. For example, none of the staff we spoke with knew if there was an HIV consultant available to refer to and said in most cases they would transfer patients whose main needs related to HIV to another hospital.

Nurses in the CCU had established a framework for link roles. This meant each nurse had an assigned link role and carried out six annual specialist sessions per year with the team responsible for their specialty. These included tissue viability, falls and dementia. Following each session, the link nurse prepared a training day and updates for the rest of the CCU team and delivered this as part of the multidisciplinary work in the unit. We saw link nurses also prepared informative information and advice displays for colleagues on their subject.

A clinical nurse specialist for young people worked in the sexual health and contraception service and supported nurses in providing care and treatment to teenagers and other young people.

Patients cared for in the ERU or MAU received the same multidisciplinary care they would receive on an inpatient ward including physiotherapy and occupational therapy.

A senior nurse in the discharge lounge had initiated work with the patient flow coordinator, pharmacy team and transport team to identify how they could improve working processes to reduce discharge delays. This formed part of a hospital pilot project in 2017 to restructure the discharge process into three component parts. The project team carried out three rapid process improvement workshops to improve the prescribing and dispensing processes of to take away (TTA) medicines. This resulted in a reduced target turnaround time from 2.5 hours to one hour and was due to be extended in May 2018.

Social workers and therapies staff met weekly to review patients with complex social needs who were medically fit but awaiting discharge. This team liaised with community services and rehabilitation teams to help identify appropriate referral pathways for patients.

A specialist stroke nurse supported the medical team on the hyper-acute stroke unit and provided care within a defined stroke and thrombolysis pathway.

We observed five multidisciplinary board rounds in acute medicine and specialist medicine. In all cases we found the discussions were comprehensive and well attended. All members of each team took part including input from therapies staff and exceptional enthusiasm and positivity from all staff involved. This demonstrated patients with complex needs received prompt review and care from a multidisciplinary team.

Staff in each specialty held weekly multidisciplinary meetings to coordinate the care, treatment and discharge of patients, including those with complex needs. This included input from social services and other community providers.

Dieticians were available for patients in each clinical specialty and in care of the elderly but cover was very low with an overall cover rate of 0.2 whole time equivalent (WTE) dieticians. This was an average and varied from the lowest cover of 0.025 WTE on the ERU, MRU and CCU to the highest rate of cover of 0.45 WTE on Clementine A ward. A team of five speech and language therapists provided cover across medical services.

Seven-day services

The trust participated in the NHS England seven day services analysis in September 2017, which identified poor findings. A re-audit in February 2018 identified improved seven day consultant cover and found 86% of patients admitted during a weekend were seen by a consultant within 14 hours.
There was no out of hours IT support for staff. This meant there was limited help available if the electronic patient monitoring system failed. A manual backup system was available.

Mental health and safeguarding teams provided 24-hour, seven day on-call referral services.

An SHO in specialist medicine was assigned to facilitate to take away prescriptions seven days a week to facilitate continuous discharge.

The endoscopy service planned to offer a seven day service from March 2018 and had initiated a recruitment programme to ensure there would be enough nurse endoscopists for this. A nurse endoscopist was available on-call out of hours, seven days a week across both hospital sites.

The stroke service, ERU and MAU were consultant-led seven days a week.

Pharmacy services were provided 24-hours, seven days a week. Outside of weekday daytime hours, staff on each ward and in each clinical service obtained pharmacy support from the on-call service.

Staff had access to a 24-hour, seven day electronic pathology ordering and results service. This meant any clinician with authorised access could order pathology tests. The electronic system was shared with GP partner practices, which meant pathology results could be tracked after a patient had been discharged and staff could check past results when a patient presented at the hospital.

**Health promotion**

A local healthy lifestyles team worked across the hospital in a health promotion capacity, including implementing smoking cessation packages with patients.

A dedicated health promotion resource area was located on the ground floor of the main hospital atrium. This included printed information published by national and international specialist organisations relevant to the medical services provided in the hospital, such as cardiac care and arthritis care. The hospital had also sourced information from organisations that provided services reflecting the needs of the local population such as support for alcohol and drug use and domestic violence.

Each inpatient ward or clinical area had health promotion resources for the types of conditions they treated. For example, on the ERU information was available on managing deep vein thrombosis and long term condition management for carers.

Sexual health and contraception staff provided care within a policy that meant all young people under the age of 18 were provided with contraceptive advice and offered printed information to take away with them. In addition staff offered free condoms and condom demonstrations. This was part of the service strategy to encourage young people to make their own choices with regards to sexual health. In addition, reception staff in this clinic were trained to give out free condoms to all patients on request.

Although the health promotion materials reflected a wide range of conditions and needs, there was no dedicated information relating to sexual health and HIV. We spoke with the HIV consultant and lead nurse for sexual health who said such information was usually only provided in the sexual health clinic. However, they said they would explore the possibility of improving resources on this topic.

Multidisciplinary teams involved with discharge planning gave patients advice and structured plans on health improvement after they left the hospital. This ranged from informal information based on their health behaviours to structured rehabilitation and health improvement plans.
Advanced nurse practitioners provided an annual health and wellbeing check to HIV-positive patients who were stable on their medicine and who had an undetectable viral load. This service ensured consultant time was dedicated to patients with complex needs and meant patients had access to a health check that could help them to maintain good health. This was an audited service and the latest results, from January 2018, indicated a need for improved uptake due to spare capacity. To achieve this, referral criteria for the service was reissued and an HIV business meeting was used to ensure clinicians understood the referral criteria.

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

Mental Capacity Act and Deprivation of Liberty (MCA/DOLS) training completion rates is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Acute Medicine’ and ‘Specialist Medicine’ directorates across the whole trust.

The trust set a target of 90% for completion of MCA/DOLS training. A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for medical/dental and nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>89</td>
<td>291</td>
<td>31%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>471</td>
<td>701</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

After our inspection we asked the trust to supply more up to date completion rates for MCA/DOLS training. As of January 2018 85% of eligible staff had up to date training, which reflected a significant improvement.

Staff used a ‘mini’ mental capacity test supplemented with a CT scan where a patient became confused unexpectedly and had not been diagnosed with dementia or diminished mental capacity. This helped to establish the level of capacity the patient had and whether staff needed to obtain specialist input.

Staff in the sexual health and contraception service used the Fraser guidelines and Gillick competencies to assess the ability of young people under the age of 18 to make their own decisions with regards to care and treatment.

Staff in the endoscopy unit obtained and documented consent in consultation room prior to each procedure.

Staff carried out a cognitive assessment with all patients admitted to Harvest A, Sunrise A and B wards. The team used this assessment to identify each patient’s mental capacity to make their
own decisions. Where they had concerns about this or the patient needed specialist care they had a number of referral pathways to use. This included to the trust mental health team, dementia lead or to independent mental capacity advocates.

Clinical staff demonstrated good levels of knowledge of the Deprivation of Liberty Safeguards (DoLS). The senior nurse on each ward led care and treatment for patients with a DoLS authorisation in place and there was a clear escalation pathway in case they deteriorated. From observing board rounds and multidisciplinary meetings we saw staff discussed the needs of patients with a DoLS authorisation within a holistic framework in which they considered their social care and medical needs.

In a June 2017 cross-site endoscopy patient satisfaction survey, 63% of patients said they would have liked more information before signing the consent form. In addition 25% said they were not given written information about sedation and 58% said staff had not discussed alternative tests or treatment. The endoscopy team implemented an action plan and the subsequent October 2017 survey noted a significant improvement in the consent process. For example 55% fewer people said they would like more information on consent. However there were limited improvements, of less than 10%, amongst patients who said they were given printed information about sedation and those who said they had a discussion about alternative treatments.

We looked at 12 examples of do not attempt resuscitation (DNACPR) authorisations. We found in each case a clinician with appropriate seniority and knowledge of the patient had completed this as part of a best interests assessment. The trust planned to introduce an audit of DNACPR completion in 2018/19 to ensure practice met the standards laid out in policies.

---

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at trust level was 33% from November 2016 to October 2017. At Queen’s Hospital the response rate was 30%, all rates were better than the England average of 25% from November 2016 to October 2017.

Performance in recommendation rates by ward is below, the highest scoring ward was Harvest Ward B with 98% and the lowest scoring ward was the Ambulatory Care Unit with an average score of 87%.

**Friends and family Test performance by ward**
The trust monitored patient feedback at both divisional and ward or department level on a monthly basis. In specialist medicine this included the percentage of patients likely to recommend the service and a measure of feedback in six key areas: communication, nurse communication, dignity and respect, information, involvement and staff. In acute medicine an additional six measures, 12 overall, were included. A detailed monthly analysis compared results at the trust and divisional level and enabled all staff to track changes over time. For example in January 2018 specialist medicine achieved a 95% recommendation rate and scores in all six feedback areas improved from the previous month. In the same month acute medicine achieved an 81% recommendation rate. This included emergency care services and results for the 12 measures indicated variable performance in the previous six months. However in each measure the majority of patients awarded the respective service with the maximum of five stars. Sexual health services achieved a 95% recommendation score and although average scores in the six criteria deteriorated from the previous month, all measures achieved a five star rating.

In June 2017 the cross-site endoscopy unit carried out a targeted patient satisfaction survey, with a response rate of 48% amongst 200 patients post-procedure. The trust did not assess results from each individual hospital although 43% of respondents had been treated at Queens Hospital.
On a scale of one to 10, where one is poor and 10 is excellent, 85% of patients rated the service between seven and 10. In addition 85% of respondents said endoscopy staff had been courteous, 80% said they were happy with the reassurance given and 83% said they were treated with dignity and respect. In a second survey in October 2017, 91% of patients rated the service between seven and 10 although 6% fewer patients said that endoscopy staff were courteous and 4% fewer said they were treated with dignity and respect. The lead nurse for endoscopy and service manager had implemented an action plan to explore and address the results that had deteriorated and planned to reaudit this in spring 2018.

Several wards had thank you boards where written compliments and thank you cards were displayed. On the medical assessment unit (MAU) thank you cards included comments such as, “A truly heartfelt thank you for all the seriously outstanding care, treatment, and attention I recently received” and “To all of the amazing doctors and nurses who saved my life and treated me in the MAU.” The theme of all of the cards and notes we read was the caring and compassionate nature of staff. On Mandarin A ward, staff had displayed a drawing from a child who wanted to express their thanks and noted, “Thank you for looking after my grandpa and being kind.”

All of the patients and relatives we spoke with said they had been treated with privacy, dignity and respect. One patient on Harvest A ward said “All of us get superb service and care. I’m very happy here; it doesn’t feel like I’m in hospital!” Another patient on this ward said “Absolutely I feel treated with dignity and respect. I’ve been beautifully cared for.”

We spent time with the reception team in the sexual health and contraception service. We saw this team welcomed patients warmly, and with dignity and respect. Where they recognised patients from previous attendances staff acknowledged this in a friendly manner without breaking confidentiality.

We spoke with eight relatives and patients on Sunrise A ward who all described the care as personalised and compassionate. One relative said “The healthcare assistant has come to see us regularly and will talk to us without rushing about. That has been really important for us to have time to talk about non-medical stuff. There’s just a feeling here of kindness and everyone takes part in it.”

During our inspection we observed staff in all roles and at all levels of responsibility treated patients, relatives and visitors with compassion and kindness. This included numerous examples on inpatient wards, in the sexual health clinic, the endoscopy clinic, departure lounge, and in public areas of the hospital. Staff demonstrated a proactive attitude to helping people and this was evident throughout the hospital.

Where patients were cared for under the bed contingency plan, staff implemented additional measures to ensure their privacy and dignity. For example, where patients were cared for in a bed bay that was already full, staff used mobile privacy screens when providing care.

**Emotional support**

We spoke with three relatives whose family members had been cared for on an end of life care pathway. In each case they told us they were, “Very happy” with the emotional support provided by nurses, doctors and healthcare assistants. They said volunteers had offered to talk during their time on the ward and said the hospital chaplaincy had been proactive in offering support.

A multi-faith chaplaincy was available 24-hours, seven days a week. Patients could contact the on-call person using details posted in public areas or ask staff to contact them.
Staff arranged psychological and counselling support for patients during and after delivering bad news. Specialist teams provided emotional support for patients living with long-term conditions and for those who received palliative care.

A mental health liaison team was available on demand to carry out depression and anxiety assessments with patients to help them access specialist support services.

We spoke with a dementia specialist nurse who was supporting a patient on Sunrise A ward. They had adapted their work schedule after a patient with complex needs would only speak to them and became emotionally distressed otherwise. We saw this member of staff had developed a positive camaraderie with ward-based colleagues and with all of the patients in the bay. For example, we saw they visibly cheered a patient up by saying in a celebratory tone “Good news! You are going home today! Your [nurses] will get you ready!”

All nurses in the sexual health and contraception service could provide emotional support and counselling to patients based on their treatment needs and which was appropriate to their age. Where patients presented with complex needs, such as relating to sexual assault, staff secured an immediate referral to the nearest specialist centre.

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

Most of the 27 patients and relatives we spoke with said they felt involved in their care and treatment. Two relatives we spoke with on Harvest A ward said they felt the team had “Gone out of their way” to communicate with them. One relative said “The [ward team] are very easy to contact. Nothing is ever too much trouble and I think we’ve been really well informed.” Patients cared for on inpatient wards generally felt better informed than those we spoke with in the receiving units. For example one patient on the elder receiving unit said, “I’ve been here three days but haven’t seen a doctor yet. The nurses are lovely but just keep saying the doctors are too busy and I have to wait.”

Another patient said, “I feel that the doctors whisper about you rather than just talk openly. I know I have a lot of problems but it does feel like they cut me out of the discussion a lot of the time.”

A relative spoke positively about communication from the clinical team when their family member received end of life care. They told us staff provided very clear explanations of care on a palliative pathway and the ‘do not attempt resuscitation’ process. They said, “I can’t rate everyone highly enough. They’ve been so kind with us all and treating [relative] as an individual and explain everything as often as we needed.”

The trust had established a minimum standard for initial interaction with patients, called ‘meet and greet’. The standard contained five key aspects including a smile, an introduction by name and telling the patient what they were there to do, such as to carry out a test or observation. The standard included the requirement that staff ask the patient or their responsible relative if this was okay. We saw from our observations this standard was embedded in care and staff followed its basic principles whenever they met with a patient.

Patients and relatives said staff did not always involve them in discussions when a transfer took place or a change of clinical team was made. For example, four patients on Bluebell wards and the ERU said they did not feel included when they had been transferred and said they had to repeatedly ask for information. In addition, one patient said they had missed out on planned occupational therapy when their therapist went on leave and was not replaced.

During our observations of medicine rounds on the ERU, MAU and Sunrise A ward, we saw the nurse explained what the medicine was for in each case and ensured the patient swallowed this before documenting it.
Each ward team displayed information on the results of patient and relative involvement exercises. This included a summary of the positive feedback they had recently received as well as how staff had made changes based on negative feedback. For example, patients had commented on both the ERU and MAU that staff were friendly and caring. On both wards they commented that there could be improvements in communication about care and treatment plans. In the MAU, the senior team provided more visible staff on the ward to ensure patients were told about updates or changes more quickly.

In the June 2017 endoscopy survey, 75% of patients said they were happy with the printed information sent to them to help them prepare for their procedure and 87% said they understood the information. Following an improvement plan, 98% of patients surveyed in October 2017 said they were happy with the printed information sent to them.

**Is the service responsive?**

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

From September 2016 to August 2017 the average length of stay for medical elective patients at Queen’s Hospital was 4.0 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 5.5 days, which is lower than England average of 6.6 days.

For elective specialties:

- Average length of stay in Gynaecological Oncology is lower than the England average.
- Average length of stay in Gastroenterology is lower than the England average.
- Average length of stay in Clinical Oncology (Previously Radiotherapy) is higher than the England average.

**Elective Average Length of Stay – Queen’s Hospital**

![Bar chart showing average length of stay for elective specialties at Queen’s Hospital compared to England average.]

*Note: Top three specialties for specific trust based on count of activity.*

For non-elective specialties:

- Average length of stay in General Medicine is lower than the England average.
- Average length of stay in Geriatric Medicine is lower than the England average.
- Average length of stay in Sport and Exercise Medicine is lower than the England average.
Volunteers were readily available at the hospital entrance and at key locations throughout the building to help patients and visitors navigate. However, signage was not always clear and distinct. For example, maps displayed around the building located the sexual health clinic but had not been updated when this service moved. Although new signage had been displayed at the hospital entrance, this used a ‘coded’ name to direct patients without naming the actual service. This code was not replicated on maps displayed in the hospital nor on the service website. This meant patients attending the hospital for a walk-in clinic could not easily locate it because the terminology used on the service website did not match that used in the hospital. We spoke with the quality improvement lead nurse for the hospital and the sexual health lead nurse about this. Both individuals told us the name of the clinic was not used on signage as a result of patient feedback but did not know why the name of the service was not clearly noted on the website.

Clinicians used a daily ward round in the medical assessment unit (MAU) to triage patients to an appropriate pathway. One pathway was used for the responsible doctor to refer the patient to a medical specialty and another pathway was used when the patient was expected to be discharged within 48 hours. In such cases staff kept patients in the MAU until their discharge was planned to reduce the delay caused by finding a short-term inpatient bed.

The sexual health and contraception service operated ‘fast track’ and ‘red card’ pathways for patients with specific needs. This meant young people who because pregnant were given rapid access to a specialist midwife, and patients identified at high risk of sexually transmitted infections were given a ‘red card’ in the community. Reception staff in the hospital prioritised these patients when making appointments or organising walk-in clinics. This clinic also provided a quick check service that did not involve a nurse examination. Staff initially checked patient needs to triage them to ensure a quick check appointment with a healthcare assistant was appropriate.

Patients were admitted to the elder receiving unit (ERU) for a minimum of 48 hours and staff began discharge planning on admission. This meant the team met each patient’s individual needs at the same time as planning what they would need for a safe, appropriate discharge. The safeguarding and social work teams worked with clinical staff throughout this process, which meant support from community nurses and social services could be put in place in advance.

Staff in each clinical area had access to language interpretation services for patients who did not understand English. This included telephone support services and face-to-face interpretation during clinic discussions and decision-making.

Therapies staff were working with a community reablement service to establish a single point of access on a trusted assessor basis as part of a reablement package of care. This aimed to reduce discharge delays by ensuring the package of care was available for when the patient was...
medically fit. In addition the team was participating in a ‘home first’ pilot that improved partnership working with community services to reduce discharge delays.

A GP-led ambulatory care service was available seven days a week from 8am to 8pm. This service was based in the medical assessment unit and provided care for patients who needed medical treatment and were not experiencing chest pains, shock or symptoms of stroke. Seven ambulatory care pathways were in place and enabled the ambulatory care team to provide dedicated review followed by either a safe discharge or admission to an inpatient ward.

**Meeting people’s individual needs**

Bluebell A and B wards had an up to date folder to help staff communicate with patients with a learning disability. This included pictorial communication charts to help as patients questions and to tell them what was planned for their care and treatment. Staff also had access to community passports, which they completed to help understand each patient’s personality and individual needs. Staff in the sexual health and contraception service had worked with the learning disability lead to prepare pictorial information and communication training for nurses to help understand the needs of patients. Where patients attended this clinic who had difficulty completing the initial registration form, staff provided one-to-one help and could use a quiet private area to help with this.

Staff on Bluebell A and B wards had developed links with care of the elderly teams to enable them to provide more targeted support for patients living with dementia.

All inpatient clinical areas used the butterfly scheme as a discreet method to indicate when a patient was living with dementia. This prompted staff to check for a hospital passport and to check the patient’s level of mental capacity. A dementia link nurse provided dedicated support for staff delivering care bundles to patients living with the condition and used the ‘This is me’ tool to help staff each patient’s background.

It was not always evident the ERU had appropriate resources to meet the needs of patients who spent time there waiting for an inpatient bed. For example, one patient told us they had borrowed another patient’s walking stick to be able to get to the toilet because the unit didn’t have any walking aids. Another patient in this unit said they had to share a walking frame with others in their bed bay as there were not enough for each patient. The trust indicated in the 2017 national inpatient falls audit that it was not trust policy for all inpatient wards to provide seven day access to walking aids for patients.

Not all inpatient areas had resources for patients to help reduce boredom or to occupy them. For example, on Clementine B ward two patients said they spent most of their time alone and bored because there was no television or day room. Although the ward was equipped with Wi-Fi neither patient had been able to access this and said did not know how to fix it. Patients on Clementine A ward said they were able to use equipment such as DVD players or music devices if they brought their own but there was no provision for items to entertain or relieve boredom on the ward.

The cardiac rehabilitation team demonstrated attention to detail in ensuring the rehabilitation programme met each individual patient’s needs. The team worked with patients to identify personal, measurable goals and adapted the programme to these. For example, if a patient wanted to set a goal of losing weight as part of their rehabilitation, the team recorded their weight at each session as motivation to track changes.

Staff in care of the elderly services had developed significant support and resources to provide extra care for patients living with dementia. For example, the dementia care team had trained
healthcare assistants in providing care and treatment to patients with the condition, and the practice development nurse had developed a dementia-friendly arts project following academic study in the fine arts. This project was the initial step towards implementing arts therapy in the wards.

Staff used magnetic symbols to discreetly note when a patient had specific needs that affected their care, treatment or communication. These included symbols for dementia, hearing difficulties, a learning disability, impaired vision and memory loss. The learning disability symbol reminded staff that the patient may need more time to process a question and respond. In addition, a symbol had been designed that met the guidance of the national Gold Standards Framework (GSF) for end of life care and indicated to staff that a patient had an advanced care plan.

The palliative care team worked closely with staff on care of the elderly wards and had developed guidance for staff in obtaining support at any time, including to an end of life care facilitator and GSF facilitator.

Staff demonstrated a proactive approach to adapting communication to individual patients. For example, on Sunrise A ward we found a staff nurse had written a number of key messages in very large letters on paper to help them speak to a patient with reduced hearing. The nurse told us the patient had become anxious and afraid if people tried to help her hear by speaking very close to her ears and had therefore developed this method. The nurse also used this strategy to help the patient understand what was happening around them, such as by writing down who different staff were and what they were doing.

Therapies staff had key involvement in the development of a new community equipment service that enabled therapies staff to order equipment ready for patient discharge.

Interpreters were readily available and staff booked these in advance for specific reviews or consultations. A telephone interpretation service was always available.

An Accessible Information Standard (AIS) task and finish group had implemented a range of improvements to information accessibility across the trust. This included the redesign of leaflets and the introduction of new technology to deliver the trust’s website. The group had also carried out an audit of the information magnets used in inpatient areas to identify patients with specific needs. The audit found staff on each ward demonstrated good understanding of the purpose of each magnets and that they were used appropriately. The trust had introduced AIS training as mandatory for all staff and as of April 2018 91% of staff had completed this.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) – admitted performance**

The referral to treatment rate remained steady between 88% and 73% but below national
Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks). This was cardiology which scored 92.9% compared to the England average of 83.5%.

Six specialties were below the England average for admitted RTT (percentage within 18 weeks); details of all specialties are below.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>Average for England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>80.7%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>76.2%</td>
<td>94.1%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>92.9%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>75%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>69.2%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>68.9%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

As part of an ongoing RTT recovery plan, the neurosciences team had introduced electronic clinical reviews. This meant clinicians were sent electronic review reminders that were measured against a trust standard of a 48 hour turnaround time. In February 2018, the service performed at 96% against this target.

The lead nurse for specialist medicine, a senior sister in care of the older person and a service improvement manager had implemented a substantive patient flow improvement programme. This included the development of a ‘SAFER’ (Senior review; Anticipate; Flow; Early discharges; React to delays) patient flow bundle and a structured patient pathway called the ‘Red2Green improvement journey’. The improvement team implemented this as a staged project with a gap analysis and multidisciplinary assessment at a midway stage. The project considered 29 patients with an average length of stay of 11 days and identified the top 10 delays and whether they were caused by internal or external factors. The improvement team planned to use the results to implement access and flow improved ways of working across the trust.

Medical staff who had been on shift or on call overnight met each morning to review all patients in the elder receiving unit and the medical assessment unit. The team also reviewed patients who were awaiting admission from the emergency department and identified issues causing delays such as staffing or incidents. The team also reviewed a ‘case of the day’ to facilitate collaborative working and ensure they safely managed patients with complex needs. This process was in addition to daily bed meetings attended by representatives from every clinical department and service as a strategy to maintain flow through the hospital.

The trust suspended reporting referral to treatment data in 2014 following concerns with data quality systems and management of waiting lists. A mixed clinical and operational team initiated a recovery plan from September 2016 to September 2017. As a result the trust significantly improved data quality and reliability and RTT performance. In November 2017, the trust achieved 91.5% in the admitted RTT percentage of patients seen within 18 weeks and in December 2017 it achieved 90.7%. During this period the trust had received an average of 3300 patient referrals per week eligible for monitoring under the RTT. This was significantly higher than the 3000 referrals...
the trust had budgeted for, which risked future sustainability. We spoke with the deputy chief operating office about this who said the greatest areas of demand were in neurology, neurosciences and dermatology. The hospital had also seen a 17% increase in demand for tier 1 and 2 dental services following the closure of a local specialist provider. Overall, the recovery programme had reduced patients on a waiting list from 77,000 to 33,000 as of September 2017 and a reduction in backlog for scheduling from 12,000 to 3000 patients in the same period.

After our inspection the trust provided the most recent RTT data to February 2018. This showed consistent improvement in performance against a 92% 18 week referral target. Between September 2017 and February 2018, 10 of 12 medical specialties met or exceeded the target in every month. Specialties that did not meet the target in this period performed between 9% and 1% under, which also represented ongoing improvements.

The trust’s bed capacity plan was in place to maintain patient flow through the hospital as far as possible when it was full to capacity, which was the case during our inspection. This involved creating extra bed spaces in clinical areas to accommodate people who were waiting to be admitted. We saw this on two occasions during our inspection; once in the MAU and once on Sunrise A ward. In both cases we saw patients were accommodated on trolleys in areas that were already full. This system was only used where the patient was medically stable and not at risk of deteriorating. Patients cared for in temporary locations under this protocol were required to have a named nurse and doctor and a structured monitoring plan in place. However, it was not always evident staff in the clinical area had the extra capacity to provide care for more patients. For example, in Sunrise A ward we saw one patient on a trolley positioned next to a window. The individual was only partially covered by a blanket, had various personal items strewn across them and did not know why they were there. Their trolley also blocked access for other patients into the bathroom. A nurse we were speaking with noticed this and attended immediately to the patient but it was not evident a named nurse had been assigned to this individual.

We spoke with nurses about the bed capacity plan on Clementine A and B wards. They told us the capacity plan meant the only private room available for discussions with relatives had been turned into a bed space and offered no window or toilet facilities. In addition we found patients were sometimes moved into a bed space before the previous patient had been transferred, which resulted in overcrowding.

The departure lounge was equipped to accommodate patients in bed overnight and had been in continual use from November 2017 to January 2018 as part of the trust’s bed capacity plan.

The sexual health service offered a walk-in service at certain times for patients without a pre-booked appointment. When demand for the service was greater than capacity staff offered a specific appointment at the next available time. This meant patients with non-urgent needs could still be seen and reduced the need for them to wait for extended periods.

A senior nurse in the discharge lounge had carried out an audit on waiting times for discharge over a three month period from September 2017. The audit found the average wait once to take away medicines (TTAs) were prescribed and transport booked was four hours.

Staff worked within a ‘home first’ vision with the local authority and community health services in relation to discharge planning. This meant staff worked to minimise the hospital inpatient stay of each patient and avoided making long-term care decisions. Staff carried this out within a framework of four pathways based on patient needs relating to their level of dependency. We saw discharge planning was carried out in line with the trust’s policy including the involvement of the multidisciplinary team and the patient. Where a patient was known to be homeless or had high levels of vulnerability, staff began discharge planning as soon as the patient was admitted. This
process supported staff in ensuring the appropriate community and specialist support agencies were involved in planning.

There was a lack of discharge coordinators in the hospital. This role often defaulted to matrons in addition to their clinical leadership responsibilities. This added significant responsibility, such as a target of 17 discharges per day for the care of the elderly matron. The divisional nurse provided support to this matron and they had prepared a business case for two flow coordinators to assist within the service.

The hospital monitored mixed sex breaches, where patients of different genders were accommodated in the same bed bay. Between April 2017 and January 2018 mixed sex breaches were rare, with seven reported between September 2017 and November 2017 and none reported in any other month.

Between November 2017 and February 2018 1163 medical inpatients were treated as outliers in non-medical areas.

Therapies staff had implemented a new demand and tracking system. This system tracked pressure on the service from different areas twice daily, which meant staff could be redeployed to reduce delays in specific areas. In addition the team had reviewed discharge planning for patients who were non weight-bearing and improved local rehabilitation pathways as a result. This involved utilising a multidisciplinary approach and facilitating pathway mapping workshops with staff to reduce the length of time from referral to discharge.

Between April 2017 and January 2018 11% of medical inpatients experienced an out of hours bed move, which meant they were moved between wards between 10pm and 7am. The site team maintained oversight of these patients and coordinated their transfer to ensure there were no gaps in care, medicine administration or review.

**Learning from complaints and concerns**

From October 2016 to September 2017 there were 258 complaints about medical care. The trust took an average of 27 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 40 working days.

- Queen’s Hospital: There were 207 complaints answered within an average of 27 working days before complaints were closed.

A summary of complaints within medicine by subject and site is below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Cross site</th>
<th>King George Hospital</th>
<th>Queen’s Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1</td>
<td>28</td>
<td>122</td>
<td>151</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>6</td>
<td>22</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Communication</td>
<td>4</td>
<td>19</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Care process</td>
<td>3</td>
<td>16</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Medication</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Waiting times for appointment</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Safety - Accidents</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Care General - Nursing Midwife</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Senior nurses on each ward offered local resolution and de-escalation of complaints through one-to-one meetings with people. For example, on Bluebell wards the nurse in charge said the main theme of complaints was communication where patients or relatives did not understand some aspects of care. To address this they provided opportunities to discuss care and treatment plans and worked to improve how staff communicated with them. The matron for elderly care held weekly drop-in ‘surgeries’ for patients and their relatives to help improve communication and understanding as a result of feedback and complaints.

Ward teams worked opportunistically to resolve minor concerns or issues before they developed into complaints. For example, if ward staff heard a patient or their relatives discuss something they were unhappy about, they proactively offered the chance to talk about this and resolve it.

Printed information was available in each clinical area that outlined the complaints policy and how to access it as well as contact information for the patient advice and liaison service (PALS). The PALS service also placed information leaflets prominently around the hospital, including in each clinical area. The trust provided information relating to complaints on their website.

We reviewed a sample of four redacted complaints from 2017 to identify how the trust investigated and resolved these. Two complaints indicated poor communication from agency nurses, including due to a lack of understanding of hospital documentation and procedures. Although the complaint resolutions indicated that the responsible matron provided feedback to the relevant agencies, it was not evident this was a structured, evidenced process that resulted in improvements. In addition we were not assured that nursing agencies responded to complaints where their staff had been involved. All four complaints demonstrated challenges with communication from staff, a lack of patient involvement and in some cases a lack of compassion through team working. For example one complaint investigation found one patient had a lack of personal care during a nightshift because only male HCAs were available and the patient preferred personal care from a female member of staff. Despite female nurses being on shift they did not help the patient because they did not feel it was in their remit. Complaint investigations including the multidisciplinary team responsible for each patient’s care although it was not evident learning led to improved practice as each complaint related to similar problems.

### Is the service well-led?

#### Leadership

A divisional director, divisional manager and divisional nurse(s) led acute and specialist medical services as part of a triumvirate leadership model within a divisional structure. Matrons led clinical care for each specialty or department and a team of senior nurses and ward managers provide local ward-based leadership.
Senior staff had a planned schedule to meet as many staff as possible across medical clinics and units. The chief nurse held weekly meetings with senior sisters and charge nurses and the chief executive held open meetings on a regular basis. The deputy chief nurse held weekly meetings with ward clerks and with healthcare assistants.

All of the staff we spoke with described good working relationships with their immediate manager and senior team. Nurses and healthcare assistants said they felt listened to when they were worried or concerned about something. For example, staff we spoke with on the coronary care unit (CCU) described their work environment as “turbulent” because of persistent short staffing. However one nurse said, “We’ve got great support from our manager and the matron, and they’ve had a big push to give us extra training to make us want to stay.” Other staff we spoke with in the CCU agreed with this and said they felt there were good incentives from the leadership team to develop their careers in the unit despite pressures from short staffing.

Ward-based staff said they felt the senior trust team was visible and accessible. For example, staff on the CCU said the chief nurse regularly visited them to provide support during the ongoing staff shortage. In addition, the chief nurse had visited the unit during a night shift to help provide care to patients and support nursing staff during a particularly busy period. Staff in Sunrise A ward said they had been nominated ‘ward of the week’ in December 2017, which meant they had regularly opportunities to meet the chief nurse and others in the senior team. We received variable feedback about the support and leadership of the medical director. For example five consultants we spoke with said they felt the medical director was accessible and supportive. However four other consultants and senior clinicians said they felt marginalised and victimised by some elements of the leadership, which they said had impacted the care and treatment they provided. Two consultants said they felt their longevity of service and commitment to patient outcomes was, “seen as less important than their compliance with the political atmosphere of the hospital, which significantly reduced their ability to provide a high quality service”.

A matron for elderly care was responsible for all four wards. This individual met with senior nurses from each ward on a monthly basis to facilitate information sharing and learning across teams. Ward managers in each specialty met monthly to review risks to the service, complaints and incidents. The meetings were also used by senior ward nurses for leadership development.

Sexual health and contraception services had experienced considerable change and restructuring since 2016, including combining nine sites to four. Although the team had planned to move from within Queens Hospital to a community site, this had been postponed. Staff told us this had been a demoralising experience. One member of staff said, “We are the forgotten service. We’re in the women’s and children’s division; neither of which fits what we do. We have no input from [trust teams]; I don’t think anyone knows what we do.”

Sexual health and contraception services were part of the women and child health division and reported safety and governance performance through the gynaecology lead. An HIV consultant led the service but was not based at Queens Hospital and there was framework in place to ensure the clinic had consistent oversight. A matron was responsible for this service but leadership responsibilities were poorly defined. For example, the senior team for sexual health on one day of our inspection could not confidently confirm the opening times of the clinic, staffing levels or the nurse in charge. This was representative of a significant hands-off approach by the trust to this service.

Three clinical leads led the allied health professional teams in the medical specialties and oncology, the rapid response team and the cardio-respiratory team. Physiotherapists and
occupational therapists were assigned to clinical wards or specialties and a band three therapist provided support across all areas.

Vision and strategy

The trust vision and strategy was a mandatory element of staff appraisals. We spoke with a matron about this who told us it had helped ensure staff felt part of the trust and not isolated in their clinical environment. All of the ward-based staff we spoke with demonstrated a good understanding of the trust’s ultimate goals. While staff had varying levels of belief in the vision and strategy each individual knew how it applied to their work and how it could help improve care and working conditions.

The clinical lead, specialty manager and lead nurse led the ‘strategy on a page’ (SOAP) for each service. This laid out the strategy and priorities for the next five years and the key quality, workforce and finance plans and goals.

Most of the ward-based staff we spoke with enthusiastically and confidently described the plans for the future for their area of work. For example, in care of the elderly wards staff said they were reassured by improvements in staffing levels and the commitment of the trust to improving working conditions and development opportunities. Nurses also said they were very proud of improvements in patient safety in relation to pressure ulcers and falls and felt well supported by the practice development nurse.

Although staff spoke positively and confidently about the trust’s plans and local developments in their area of work, there was limited evidence of a specific vision and strategy for each division. For example staff shared strategies for improvement with colleagues within their specialty but were not aware of work at divisional level for future development.

At the time of our inspection the sexual health and contraception service was undergoing a retendering process. This meant another organisation could shortly become responsible for delivery. However, the staff we spoke with had developed a strategy for the immediate future if they were successful in their bid to keep the service. This would include new treatment and referral pathways with primary care services to improve patient access, new referral pathways into gynaecology, and a focus on providing patients with greater choice in accessing the service.

Culture

Each inpatient ward displayed the ethos of their team and department, which all staff had contributed to developing.

Staff in all wards we visited described their team morale as good. Nurses in the CCU said the unit had won the trust’s ‘ward of the week’ award on four occasions, which they said was good for the working atmosphere and job satisfaction. Although staff described the working environment in their respective clinical areas as positive, some consultants described poor working relationships with the trust executive team. For example, some described a disconnect with the senior leadership team and said the trust was excessively hierarchical. However, other staff we spoke with said they felt the trust had removed layers of hierarchy. One senior nurse said “It feels like I can approach anyone I want for help now; whoever the most appropriate person is. Before I had to follow a complicated escalation system; not anymore.” Other staff noted incentives such as a ‘terrific ticket’ scheme, which senior staff used to reward individuals for good work.
Staff were encouraged to present innovative or new work at governance meetings as a strategy to share learning and recognise good practice. For example, the speech and language therapy team had presented their work introducing fluoroscopies for patients living with chronic obstructive pulmonary disease. This was part of an overall culture that rewarded new work and progress.

Five patients we spoke with on Clementine A and B wards and Sunrise A and B wards commented on the positive working culture they had observed amongst staff. One patient on Clementine B ward said, “The atmosphere between staff seems pleasant. It makes being here more bearable and I think it makes everything overall more relaxed.” We spoke with a matron about this. They said, “When we praise and boost staff every day we see the impact and the improvements.”

Junior doctors in some areas of acute medicine described persistent difficulties in making appointments with their education supervisor and ongoing cancellations of teaching due to short staffing. Three junior doctors we spoke with said there was overall dissatisfaction with some elements of teaching because ongoing shortages of doctors meant they did not have time to access it.

There was a demonstrable, palpable drive to improve the working culture of the hospital through multiple engagement strategies and open and honest communication about how to meet increasingly challenging demand. With the exception of some consultants and staff in the endoscopy unit, staff at all levels of responsibility and in all areas of medical care services spoke positively about this. For example, one nurse on Sunrise A ward said “We used to work in silos. It was insular and I never felt thrilled about coming to work. Everything seems to have changed now. It just feels different, like they [hospital senior staff] genuinely want to make things better.” Senior staff said the winter pressures period had given them concern for staff wellbeing and welfare. This was reflected in our conversations with individual members of staff but they also noted they felt increased management presence and access to senior staff had mitigated this to some extent. Staff in the endoscopy unit said they felt morale was very low and they were concerned about ongoing staff attrition and a failure to recruit. One nurse said “We worked very hard to get JAG accreditation but we haven’t even had a thank you from the trust. It feels like we’ve been forgotten.” Two other members of staff we spoke with agreed and said they felt the service was unsustainable at present. Some staff we spoke with in Clementine A and B wards said they felt insurmountable pressure from increasing patient numbers and an inability to recruit.

Staff in some teams said efforts to improve the culture still needed a lot of work. For example, one senior nurse who worked across multiple wards said communication and engagement depended on the approach of local managers. They said this led to specific groups of staff refusing to engage with new projects, which created significant challenge.

**Governance**

Medical care services were provided within the acute medicine division and the specialist medicine division. Both divisions were cross-site, which meant governance and quality monitoring systems applied to both hospitals. Sexual health services were provided within the women and child health division although services were also provided to men of all ages.

The trust had introduced a new governance structure for management, administration, and clerical staff. Specialty managers and patient pathway managers worked with divisional leadership triumvirates to deliver care and treatment. The teams focused on managing waiting lists and referral to treatment times (RTTs), which meant clinical teams could focus more consistently on
the delivery of care and follow-up. Divisional teams attended weekly access meetings and specialty teams held weekly patient tracking list (PTL) meetings as part of the governance of managing patient waits and referrals. In addition the trust ensured consistent scrutiny of waiting lists through a joint agreement with NHS England, NHS Improvement and local clinical commissioning groups (CCGs) that resulted in monthly task and finish meetings for certain specialties. Divisional leads held overall responsibility for RTT performance and were supported by patient pathway coordinators.

A monthly specialist medicine divisional board reviewed incidents, complaints and other areas relating to risk and quality and safety assurance such as training compliance. Key discussions and audit results from the board meetings were presented monthly to the quality governance steering group along with areas for escalation. Services in acute medicine used a monthly business performance meeting to monitor factors such as workforce recruitment and sickness and patient experience. We looked at the minutes for meetings from September 2017 to February 2018 and found them consistently well attended by senior specialist staff representing a range of roles. We saw meetings were used to track service, quality and patient outcomes and these were shared appropriately with other services and benchmarked against national standards.

The senior team on each ward used a clinical governance and quality dashboard system to assess safety and performance against 28 criteria include staff vacancies, use of agency staff, patient feedback, mortality rates and patient safety audits. We looked at the dashboard for each medical inpatient area from April 2017 to December 2017 and found there were no gaps in data and quality performance was measured based on the needs of patients in that specialty.

Trainee doctors attended monthly clinical governance feedback meetings with the governance lead. These were in addition to monthly patient safety summits and the time was used to discuss incidents and individual patient case reviews. Doctors told us it was a useful process to ensure they remained up to date with learning from investigations.

Matrons, senior nurses and divisional nurses attended a monthly quality and safety meeting for their division as a strategy to identify cross-specialty working and learning opportunities.

Clinical governance systems incorporated medical care services at King George Hospital. This meant that meetings to review incidents, complaints, falls, and pressure ulcers included instances at the trust’s other hospital. This strategy enabled staff to share learning with colleagues across the trust to contribute to a learning culture. In addition, matrons introduced round table discussions within 48 hours of a serious incident with staff involved and clinically appropriate colleagues to review the time leading to the incident. Senior teams had also expanded clinical governance systems to ensure temporary staff were including in learning opportunities. For example, following an incident that involved a patient sustaining a bone fracture from a fall, senior nurses invited agency staff to the round table discussion as part of the investigation. This meant learning was shared beyond the immediate permanent team. The matron who led this instance said agency staff had provided very positive feedback afterwards, noting they were rarely offered the chance to engage with clinical governance processes.

Management of risk, issues and performance

Senior planning teams had adapted capacity to ensure they could meet demand during the winter pressures period. For example, the trust used past data and national demand and capacity information to pre-empt which clinical specialties would be under the most pressure. They rescheduled clinics to release consultants to inpatient wards as a strategy to ensure they could
meet the needs of patients most at risk. At the time of our inspection the trust had not cancelled any future elective inpatient admissions and planned to achieve a consistent 92% RTT for 18 week waits by April 2018.

Divisional teams used risk registers to monitor risks to the service, including to assess their likelihood and severity. Divisional risk and clinical governance teams assigned each risk to a responsible lead and monitored controls and mitigation on a monthly basis. As of February 2018 there were 16 live (unresolved) risks on the risk register for specialist medicine and seven risks for elderly care. In specialist medicine five risks were categorised moderate, 10 risks were high and one risk was extreme. The extreme risk related to gastroenterology but did not apply to Queens Hospital. We reviewed all of the risks that applied to this site. Although each risk had details of control measures, gaps in control and an assessment of adequate assurance there was not always evidence of timely and frequent reviews. For example one high risk related to a lack of staffing on Mandarin A and Clementine B wards and had been entered onto the register on February 2017. However there was no documented interim review and the next review was not due until March 2018. In addition the risk lead indicated they were only ‘partially assured’ by the control measures and there was no update to staff numbers despite the risk reflecting 19 nurse vacancies. A risk action plan had been completed 11 months after the risk was entered, which indicated senior nurses were to move staff from other wards to provide cover. It was not evident this was an effective risk control as other wards also demonstrated staff shortages. Where risk controls relied on ward or departmental staff working with other services in the hospital we were not assured that this took place in a timely or effective manner. For example a moderate risk in endoscopy related to problems with the booking system that meant patients often arrived for their appointments on the wrong date or at the wrong time. This resulted from two different systems in place that could not communicate with each other resulting in a duplication of work. The risk had been raised in May 2017 and the next review, in January 2018, noted that the service manager was awaiting feedback from IT. Two control measures were in place however they were noted to provide no assurance. There was no indication why input from the IT department had not been obtained in the previous eight months.

The care of the elderly risk register noted a shortage of nurses as an extreme risk and the risk lead had prepared an action plan that partially assured the control measures although there was a seven month gap in documented reviews. The only low risk on the register for this service related to potential harm to patients caused by delays and lapses in staff safeguarding training. This had been entered in October 2015 and not reviewed until August 2017, a gap of 23 months. A target for a risk action plan in October 2017 had not been met by February 2018.

Between February 2017 and January 2018, risk leads had closed nine risks in specialist medicine and closed one risk in elderly care.

The hospital had implemented a clinical harm programme as a governance strategy to reduce the risk of long waits by identifying patients at greatest risk. Since implementation in September 2016 the programme team, led by the associate medical director and deputy COO, had carried out 4000 clinical harm reviews with no moderate or high harm cases as a result. All patients who were at risk of breaching a 52 week wait underwent a clinical harm review and the team carried out a review on a sample of patients who had waited 30 weeks or more.

Catering and cleaning services were provided by an external company. We spoke with the nurse in charge on three wards about the management of service standards and issues. Nurses told us a named supervisor was always on site for the company and was readily available. They also attended fortnightly meetings with a manager from the company to ensure issues were resolved and standards of good practice were established.
Ward managers and matrons held monthly team meetings in each ward or clinical area and used this time to discuss incidents, complaints, and new policies or protocols. For example, at the most recent meeting in the CCU staff had discussed a new bundle of care for circulation pathways before they were formally introduced to the unit.

Matrons and their nurse teams demonstrated flexibility in addressing staffing and leadership needs in specific areas. For example, a new matron in care of the elderly engaged with three nurses from other wards and departments to immediately transfer them to a ward that presented significant risk due to nurse shortages. The matron and divisional colleagues provided training and guidance in discharge planning and practice development nurses worked with the nurses to develop their existing skills.

The health and safety steering group met quarterly with representatives from each clinical and operational area. This group reviewed incidents, complaints and other governance and intelligence relating to patient and staff safety. The group considered a security, violence and aggression report that enabled them to track incidents and identify trends. The group included senior staff responsible for health and safety and fire safety and so included business continuity planning.

Information management

The trust had engaged external specialist organisations to ensure to reporting for RTT was marked by reliable and accurate data. This included establishing new data quality criteria and a new framework for PTLs. Divisional teams used weekly data quality and validation reports to respond proactively to concerns or delays at specialty level.

In most areas we saw staff maintained appropriate standards of data protection, including locked notes trollies and locking computer screens when not in use. We found staff on the CCU kept a notes trolley open and unlocked with unsupervised access during one day of our inspection. Although access to the unit was controlled by a security system this did not ensure patient records were always secure when they had been left unattended.

There was not a system in place to ensure information displayed on wards for staff was always up to date. For example, we saw one notice at a nurse station that instructed nurses to call a hospital out of hours coordinator instead of contacting doctors directly overnight. None of the staff on this unit knew about the initiative and doctors we spoke with said they did not know there was an out of hours coordinator. On another unit we found a notice for staff relating to a HIV referral pathway. The senior nurses in this unit said they did not know who had displayed the notice and they were not aware of this particular referral pathway. The HIV pathway available on the unit was dated 1997 and referred to a significantly out of date clinical approach to treating HIV. We escalated this to the nurse in charge who removed the information although we could not identify why staff had not removed or updated this policy.

Engagement

The divisional team in specialty medicine had implemented an action plan following results from the 2016 staff survey. These indicated staff frequently experienced bullying, harassment, discrimination or aggression from patients or visitors to the hospital. The hospital implemented a task and finish group to identify if such instances occurred more frequently in certain wards or services and displayed ‘zero tolerance’ behaviour posters across the site. Staff were also provided with self-defence, de-escalation and breakaway training. In total the division or trust implemented 29 initiatives as part of the action plan, including several to contribute to becoming an employer of
choice for staff. In February 2018 all actions were scheduled to be completed within their predicted timeframe.

The senior team on Bluebell A and B wards had carried out two keeping in touch (KIT) days in 2017 to improve communication and engagement with staff. As part of the days staff took part in debriefs of specific patient cases, joint training, and spent time away from the ward as a team-building exercise. The senior team on these wards demonstrated keen awareness of how staff were feeling and planned new engagement activities to identify any changes the senior team could make to help staff in their work. In addition, the ward had experienced no staff sickness over the Christmas period, which the senior team said reflected their ongoing work to build staff relations. The PDN assigned to the Bluebell wards planned to include healthcare assistants in the next KIT day to further develop the training they had undertaken in care of the deteriorating patient.

Respiratory team meetings had increased from quarterly to monthly to enable more staff to attend as part of the team’s broader strategy to improve engagement.

The chief nurse organised regular ‘meet the chief’ events and all staff were encouraged to attend. Ward staff said they felt this was a genuine approach to engagement and that senior ward staff always tried to cover them if they wished to attend.

Staff on Bluebell A and B wards had engaged with patients and their relatives to gather feedback about how they could improve stays on the ward. Feedback indicated people often felt bored when on the ward for a long time. As a result, the team had met with the trust’s charities to source table games and other resources to help reduce boredom.

Ward-based staff had contributed to the significant changes in staffing implemented on Bluebell A and B wards. For example, changes to the nursing establishment per shift was influenced by staff feedback regarding safety. Increases to staff numbers based on the number of patients with a tracheostomy was also implemented as a result of feedback from staff.

Senior staff in care of the elderly wards had initiated a ‘little things jar’ system on each ward. This was a jar on the nurse station where staff could submit feedback and ideas anonymously. The matron and the ward managers reviewed these weekly and discussed them at monthly staff meetings.

**Learning, continuous improvement and innovation**

The senior nursing team on Bluebell A and B wards had restructured the staff team and created new opportunities for staff nurses to develop and achieve promotion. This was in response to ongoing vacancies and staff turnover, and part of a broader effort to upskill staff and reduce attrition to other specialties. The ward leadership teams also reviewed the skill base and experience of the band seven nurses and provided new training and leadership opportunities to ensure nurses had experience in both clinical leadership and human resources-based management processes. The CCU and Clementine A and B wards were also actively involved in a band six nurse leadership development programme. Nurses on the Clementine wards had access to a year-long structured external development programme that helped them develop skills in appraisals, managing teams and managing complaints.

Staff were encouraged to be research active and as of February 2018 there were 45 live research projects in medicine. This included in cardiovascular, dementia, neurological, skin, diabetes, oral and gastrointestinal, hepatology, metabolic and endocrine, respiratory and stroke services.

A quality improvement lead for respiratory medicine worked with junior doctors and nurses to design and deliver research programmes that improved patient care and outcomes. We looked at two research programmes and saw they were structured against ‘plan, do, study, act’ (PDSA)
research methodology and carried out in the context of National Institute for Health and Care Excellence (NICE) clinical guidance.

As part of the trust’s overall strategy to improve engagement with staff, individual senior staff and some specialist and allied health professional teams had set up live social media accounts. They used these to distribute news and information about pilot schemes or new work processes as well as to recognise staff for innovative work. For example, the chief nurse encouraged staff to use their social media account to inform them of work or projects they were excited about or wanted to showcase as good practice.

Practice development nurses in acute medicine were leading ten innovation and development projects covering multiple areas. These included facilitating nurse attendance at conferences and launching an ‘eating matters’ event that would help to promote effective eating habits for patients with complex dietary needs.

The care of the elderly wards matron had worked with clinical colleagues and human resources staff to identify improved recruitment practices to help identify new talent. For example, they used the outcome of exit interviews with departing nurses to modify the terminology of job descriptions to ‘care of the older person’. This attention to detail appealed to staff whose first language was not English and those who associated ‘care of the elderly’ with community or district care. As a result, the service successfully recruited 20 new nurses.

The clinical neurophysiology department was piloting an electronic referral system that enabled patients to be referred and admitted on the same day. This was part of a drive to achieve no admission delays. In addition staff sent patients ‘good news’ messages when their results came back as expected or on target as part of a drive to improve patient engagement and encouragement.

The lead nurse for specialist medicine, a senior sister in care of the older person and a service improvement manager had implemented an innovative ‘Red2green’ programme to improve patient flow. This involved reducing discharges and identifying safer pathway-based working against a five-stage process named ‘SAFER’. The team identified collaborative working, positive patient feedback, clinical leadership and training as notable positive elements of the pilot stage. They had established a plan to further develop and embed the programme, including the roll-out of a data masterclass for ward managers and the introduction of champions to drive the programme forward. The team analysed discharge data in each clinical area and identified reasons for delays such as additional pressures on junior doctors. The team used this information to identify how working practices or standards could be adjusted to improve patient flow. This project reflected a substantive, sustained approach to understanding patient flow and building on this to deliver a more efficient process.

The therapies team was leading the establishment of an allied health professional innovation group that would improve multidisciplinary collaboration and the sharing of ideas. The SaLT team was research active and was using the outcomes of innovative projects to improve patient care and to develop national guidance. This included adjusting radiation doses during video fluoroscopy procedures to produce better images and improve diagnosis and a project with patients with dysphagia to reduce rates of infection.
Facts and data about this service

We inspected Queen’s Hospital on an unannounced visit as part of the new phase of our inspection methodology.

The hospital provides emergency inpatient surgical treatment, elective (planned) inpatient surgical treatment, and day case surgery across a range of specialities including: general, vascular, ear, nose and throat (ENT), ophthalmology, trauma and orthopaedics, colorectal and maxillofacial surgery. Upper gastrointestinal and neurosurgery services are regional centres for the local catchment population, and parts of North East London and Essex.

The trust had 37,989 surgical admissions from September 2016 to August 2017. Emergency admissions accounted for 12,610 (33%), 18,477 (49%) were day case, and the remaining 6,902 (18%) were elective (planned) surgery.

(Source: Hospital Episode Statistics)

The surgery service is one of six divisions within the trust. It provides general and specialist surgical treatments and care. There are a total of 254 inpatient surgical beds at two sites in the London Boroughs of Redbridge and Havering: 179 at Queen’s Hospital, Romford and 75 at King George Hospital, Goodmayes.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

At Queen’s Hospital there are 16 operating theatres, a post-operative recovery area, four surgical wards, a neuro-surgical ward within the medical division, a surgical assessment unit for rapid assessment of patients referred by their GP or by an emergency department (ED), a day surgery unit providing a pre-assessment service and admissions area for ambulatory patients, and a surgical step down unit (SSU). The SSU is for patients who have previously been in high dependency or the intensive therapy unit and who require closer supervision and monitoring due to the acuity of their illness or condition. During our inspection we visited all of these areas and the discharge lounge.

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 trust set a target of 90% for completion of mandatory training.

The trust required that all staff completed mandatory training in a range of topics, and enabled protected time for this to be completed either online or face-to-face. Topics included conflict resolution, infection prevention and control, health, safety and welfare, safeguarding vulnerable
adults (adults at risk) and children, life support, first aid, information governance, display screen equipment, fire safety essentials, fire warden training, fire emergency evacuation and drill essentials, first aid, equality and diversity, informed consent, infection prevention and control, health and safety essentials, and moving and handling. All staff we spoke with told us they were up to date with their training. However, managers told us there had been a decline in attendance at some mandatory training. We saw this was repeatedly recorded as a concern in the minutes of the Quality and Safety committee meetings in October, November and December 2017. Measures were in place to ensure staff attended which included treating non-attendance as a disciplinary matter.

The information provided below covers the trust’s ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust, and was not provided at a site level. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>307</td>
<td>354</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>304</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>293</td>
<td>354</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>290</td>
<td>354</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>285</td>
<td>354</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Following our inspection we asked for further information about adult life support training as this was not available during our visit. We subsequently received information that showed the trust annual compliance target for 2017 was 90% for adult basic life support training within the surgery and anaesthetic division. Divisional performance papers show that the compliance rate as of December 2018 was 83%.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing staff is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>557</td>
<td>566</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>552</td>
<td>566</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>550</td>
<td>566</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>541</td>
<td>558</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>545</td>
<td>566</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>539</td>
<td>566</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>538</td>
<td>566</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training data provided by the trust shows that medical staff were not meeting the trust target of 90% in any training modules. Surgical nursing staff were meeting the target for all mandatory training courses except for Moving and Handling.

We were provided with more up to date information during the inspection. ‘Best’ (BHRUT education staff training) was a piece of software that recorded appraisals and mandatory training. Best recorded everything that the trust felt was mandatory. This included competency based items that were in addition to standard mandatory training items. For instance dementia awareness, end of life care, mental capacity and smoking cessation advice. In addition to this, each ward carried out further specialty specific competencies that also counted to trust mandatory training statistics.

There was a nominated sepsis lead for surgery who had been in post for two months. They attended monthly meetings, the sepsis steering group and a trust wide meeting where all divisions came together to share knowledge and issues. One priority had been to increase compliance with sepsis training for nursing and medical staff, which had taken place. There was now a key trainer for each surgery ward at the hospital who had tier 1 and tier 2 training in sepsis management.
They carried out on the spot training on wards and raised awareness. Staff we spoke with told us they had been sepsis trained on starting at the trust, plus an annual update online.

There were reminder systems for staff to prompt them when they were overdue for their mandatory training. The trust provided software to record appraisals and mandatory training compliance, and a weekly trust wide report on compliance with mandatory training was shared with staff. Due to the way data was held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site.

**Safeguarding**

The trust set a target of 95% for completion of safeguarding training.

The information provided covers the trust’s ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust, not at a site level. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>292</td>
<td>354</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

For medical/dental staff within surgery, the trust failed to meet the training target for both applicable safeguarding courses.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>521</td>
<td>534</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>541</td>
<td>566</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>24</td>
<td>32</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

For nursing staff within surgery, the trust met the training target for two of the three applicable safeguarding courses.

There were processes in place setting out what the organisation and staff should do to keep people safe from abuse. The trust’s safeguarding policy could be found on the intranet, which
was accessible to all staff. There was also a hard copy printed out and left in a resource folder on the wards. The policy for adult safeguarding was within the review date.

All the staff members we spoke with were able to identify abuse and describe the process in which they raised and reported safeguarding concerns. They gave examples of when this would be necessary.

There was a trust safeguarding team, and a safeguarding lead within each ward or area, known as the safeguarding champion. Information on the reporting process and key contacts for adult and children’s safeguarding was displayed in wards and the surgical areas. All the staff we spoke with knew where and how to access this information if required.

**Cleanliness, infection control and hygiene**

The trust had identified areas for improvement in infection prevention and control (IPC). A newly established IPC team was appointed in 2017 with the purpose of implementing a five year strategy to educate staff across the organisation on principles of IPC including hand hygiene. The team worked with infection control specialist nurses, team leads in the operating theatre department, and link staff in all ward areas to share information and keep colleagues updated on issues and developments. We spoke with link nurses who attended regular meetings, shared information, and were able to offer advice to colleagues. We spoke with the infection control leads in main theatres. The IPC team were based at Queens and had 10.6 whole time equivalent nurses and 1.6 administrative support, with specialist nurses based at both sites of the trust.

Information provided following our inspection showed there had been less than 1% surgical site infections for the periods January to March 2017, April to June 2017, and October to December 2017. This was below the national average of 1.3%. For the period July to September 2017 there had been two reported surgical site infections which equated to 1.6% which was above the national average.

We spoke with infection control link nurses on wards who told us that IPC specialist nurses had a daily presence on wards which was mainly surveillance focussed, especially of hand washing practice. Incidents of infection on wards were not recorded in any register. Recording the number of infections on wards was limited to summaries of meticillin-resistant Staphylococcus aureus (MRSA) and C.Diff statistics. Based on the trust harm free care report, there had been one case of MRSA and one case of C. Diff in surgical wards between Apr 2016 and March 2017. There were no records for ordinary streptococcal infection, which usually caused the most morbidity in wounds.

Patients, relatives, staff and managers we spoke with consistently told us they were satisfied with the cleaning services in the ward and operating theatre areas. All areas we inspected were visibly clean and safe. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning and decontaminating equipment, and for cleaning the environment. We observed theatre staff cleaning the theatres between patient cases and we observed nurses on the ward wiping down beds, chairs and equipment before and after use. Clean equipment was identified by ‘I am clean labels’ so that staff were clear when it was ready for use. An external company was used to provide a deep clean to the theatres. There was a weekly audit provided by the cleaning supervisor, which was reviewed at the quality board. We observed staff wearing personal protective equipment, including aprons and gloves, when delivering personal care.
protocols were followed in theatres.

We observed all staff groups 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). Hand washing and sanitiser facilities and personal protective equipment (PPE) were readily available and clearly signposted in all departments we visited. Hand hygiene sections of the monthly IPC audits suggested gel dispenser were available and good hand hygiene standards were observed in the surgery division.

The IPC team conducted monthly audits of all clinical areas to assess against the measures listed in Essential Steps to Safe Clean Care as listed in Department of Health (2003) Winning ways: Working Together to reduce Healthcare Associated Infections.

We saw side rooms being used for isolation purposes where patients had a known or suspected infection, with doors shut and appropriate signage alerting staff and visitors of the infection prevention and control precautions to take. If staff had any concerns about who or how to isolate patients, there was a clear isolation risk policy for them to follow. Each bed in a bay had disposable curtains used for privacy and dignity. These curtains displayed dates of when they were last changed.

Furniture was clean and in good condition, fully wipe-able and compliant with Health Building Note (HBN) 00-09: Infection Control in the Built Environment.

Compliance with cleaning was ensured by monthly cleaning audits as well as spot check audits. These audits were carried out by the housekeeper supervisor and then shared and discussed with the ward matron. If the audit found below 95%, compliance action plans would be formed and an increase in spot checks undertaken.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins in accordance with HTM 07/01 The Safe Management of Healthcare Waste 2013. We saw sharps bins were securely kept and not full. We observed general and clinical waste bins in each bay and also in the corridors of the ward. These bins were not overfilled and were labelled clearly.

Environment and equipment

Systems were in place to ensure the environment was safe and secure with access to theatres and other clinical areas. Access was limited to specific staff using a digital keypad access system or intercom for visitors. We found a clean and tidy environment in all patient areas we visited. Equipment had been PAT tested and was in date. Equipment was clearly labelled and stored in an organised fashion including in corridors.

There was safe provision of emergency equipment with accessible resuscitation trolleys and equipment used for the management of unanticipated difficult airways. Staff informed us that the emergency equipment was always kept in the same place so that they knew where to locate it. There was piped oxygen and suction equipment in each bed space in the ward and recovery areas as well as call buttons to be used in the event of an emergency.

Resuscitation trolleys and call bells were checked regularly by staff that were competent to do so. Trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. Records we looked at showed that the
resuscitation trolleys were all checked daily with stocks of equipment and consumables maintained by designated staff.

All consumables we saw were appropriately stored and within their expiry date. Equipment was serviced internally or by the manufacturer, with a record of equipment maintenance being kept centrally. Monthly reports were produced of the equipment due for maintenance so that this could be scheduled within the timeframe and without interfering with clinical practice. Staff we spoke with told us they had no concerns about availability or suitability of equipment.

Equipment was stored safely. Products deemed as hazardous to health were in locked cupboards or clinical rooms or rooms that were only accessible to authorised staff.

Arrangements for the delivery and removal of waste and other equipment were clear. We observed waste being separated into the correct waste disposal bags and saw that bins used for the disposal of sharp objects were filled to a safe level.

Assessing and responding to patient risk

We reviewed 41 patient records in ward and theatre areas. We saw standard broad risk assessment tools completed on admission. This was followed by use of specific tools for pressure ulcer risk, moving and handling, and bed rails risk, nutrition, falls, and dementia screening. The risk of blood clotting was noted on medication charts.

Each patient’s fitness for surgery was assessed using the American Society of Anaesthesiologists (ASA) Physical status classification system. This is a global score that assesses the patient’s fitness to be given an anaesthetic for a procedure. We saw that additional risks for all patients undergoing a surgical procedure were assessed and responded to by applying the World Health Organisation (WHO) surgical safety checklist in the operating theatre environment. The purpose of the checklist was to check and approve all safety elements of a patient’s operation before proceeding. This included, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. We observed active involvement of all team members when following the checklist. The WHO checklists were reviewed at safety huddles as well as weekly during the operating department team meeting.

The operating theatre department undertook audits of the WHO checklist on a monthly basis. Prior to July 2017, these audits were done manually. Since July 2017, an electronic theatre data system enabled these audits in real time. Reporting of compliance with completion of the WHO checklist took place in the daily safety huddle in the operating theatre department. WHO audits showed that staff were consistently completing the WHO checklist correctly.

The service had implemented the National Early Warning Score (NEWS) system developed by the Royal College of Physicians for the detection and response to clinical deterioration in adult patients monitoring for of adult patients on wards. In all of the patient records we looked at we saw the early warning scores were completed electronically and used appropriately. A mobile clinical system that monitored and analysed patients’ vital signs provided clinicians with accurate, real time information to provide risk scores and trigger the need for further intervention. We saw this happened throughout our visit and staff confirmed this was normal practice.

It was recommended by the National Patient Safety Agency in 2010 that the World Health Organisation (WHO) surgical safety checklist should be used for every patient undergoing a surgical procedure. We saw a policy had been issued across BHRUT to enable the use of the
WHO checklist and monitoring of its use. The policy included a template for the checklist and stated it would be applied for all patients having surgery. During our inspection we saw the checklist applied without distraction or interruption.

We saw all patients were asked about their medical and social history at their initial pre admission consultation to assess their suitability for treatment; this included assessment of potential risk factors, prescribed medicines and recreational drugs.

Records we looked at showed that following surgical procedures patients were monitored in the immediate post-operative period for at least 30 minutes by a registered practitioner in the recovery area until they were fit for transfer to the ward. Once they were back on the ward observations continued as long as the clinical condition indicated.

All of the patient records we looked at contained venous thromboembolism risk assessments (VTE) which staff completed prior to treatment. The risk assessments informed staff if preventive treatments were required.

Staff told us that Sepsis 6, which is a bundle of medical therapies designed to reduce the mortality of patients diagnosed with sepsis, was emphasised at induction to the trust and was widely promoted in all areas. This was in line with NICE NG51 Sepsis: recognition, diagnosis and early management. Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. A nominated sepsis lead (matron) was responsible for delivering and monitoring compliance with training in this area and we saw that this happened in face to face sessions and on line.

There was a critical care outreach team, who supported staff with management of deteriorating patients on the ward. Staff told us that the critical care outreach team were easily accessed by ward staff to gain help for deteriorating patients. Staff also told us that consultant advice or review was also available when needed.

Daily safety briefings and board rounds were undertaken to highlight any patient that may be deemed at risk. Hospital-wide patient safety summits were held on a weekly basis, with all staff welcome to attend, and learning from reviews of clinical incidents was shared across both trust hospital sites. However, staff told us and it was reported at the quality and safety committee meeting that poor incident closure was related to a lack of engagement by medical staff about incidents.

We observed a theatre huddle and safety brief which all staff attended. Issues that were discussed included what went well yesterday, what could have gone better, any newly reported incidents, staffing, sickness levels and any patients that may be a high risk. We also observed multi-professional ward board rounds which included discussion surrounding patients social needs, mobility, falls risk, pain, drugs and discharge.

National Safety Standards for Invasive Procedures (NatSSIPs) were embedded in the organisation. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) and dedicated LocSSIP checklists were in place for invasive procedures such as endoscopy, catheters, CV lines and tracheostomies. A working group was in place to review and develop future checklists and standards.

Arrangements were in place and staff had good knowledge of what to do in the event of a patient deteriorating. Resuscitation equipment was checked regularly and staff reported regular simulations took place.
Some systems were in place for patients following their discharge from the surgical service. At discharge, patients were provided the ward telephone number or directed to the 111 service, their GP, or the emergency department if they had concerns out of hours.

**Nurse staffing**

The trust reported their staffing numbers for nursing staff as at September 2017 for surgery as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>408.61</td>
<td>361.63</td>
<td>89%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Decisions about staffing levels and skill mix were based on patient acuity and dependency and supported by an evidence based workforce planning tool: NICE Safe Staffing guideline (SG1). Staffing was planned using an electronic rostering system which included alerts for anticipated and unanticipated absences such as study leave, annual leave and sickness. Agency and bank nurse shifts would be booked to cover shifts that could not be covered by permanent staff.

Senior managers in the surgery division reported that the nursing vacancy rate had been reduced from 21% to between 8 and 9 % over the last 18 months, which had been achieved by an improved supportive culture. For example increased number of Band 6 staff meant that there was now a Band 6 or senior Band 5 on every shift. The appointment of a new practice development nurse post specific to the surgery division had provided additional support and enablement of learning and development, and was felt to have aided staff retention.

During our inspection, we found that actual levels of staffing met planned numbers. However, there remained high vacancies, particularly in nursing. Divisional performance papers from January 2018 showed a nursing vacancy rate of 12%, higher than the trust target of 9%. Staffing of the wards was managed closely with temporary staffing employed to fill any gaps, and was reviewed on a shift by shift basis at bed management meetings, and vacancy rates over all were reviewed in divisional performance meetings. Many permanent staff had also joined the hospital staff bank.

We discussed staffing issues with the senior leadership team during the inspection, and felt the trust was addressing as much as possible. Staff were actively being recruited and the issue was documented on the risk register.

From October 2016 to September 2017, the trust reported a turnover rate of nursing staff of 1% in surgery. This met the trust target of 13%. Overall turnover rates for all core services at the trust for nursing staff were 1.4%. A breakdown by site of turnover in surgery of nursing staff is below:

- King George Hospital: 1.2%
- Queens Hospital: 1.1%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

We saw that expected and actual staffing levels were displayed on notice boards and that gaps in staffing levels were filled by temporary staff from the hospital bank or an external agency where possible.
From October 2016 to September 2017, the Queens hospital reported a sickness rate of 2% in surgical care for nursing staff. This met the trust’s target of 2.8%.

Managers we spoke with told us that sickness monitoring remained a priority and that there had not been any significant impact on staffing as there were effective arrangements to manage sickness with temporary staff including bank, locum and agency.

There had been an increase in agency usage despite recruitment in some areas. From October 2016 to September 2017, the trust reported that bank and agency staff covered 47% of vacant shifts within medical care. Breakdowns by site were not provided by the trust.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

The trust reported their staffing numbers for medical staff as at September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>225.86</td>
<td>189.27</td>
<td>84%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From October 2016 to September 2017 reported a turnover rate of 1.3% in surgery, which met the trust target of 13%. Overall turnover rates for all core services at the trust for medical staff were 1.2%. A breakdown by site of turnover in surgery of medical staff is below:

- King George Hospital: 0.3%
- Queens Hospital: No medical staff were assigned to this site on the trust HR system.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The trust reported that 91.7% of vacant shifts within surgery between October 2016 and September 2017 were covered by bank or locum colleagues.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

From August 2017 to August 2017, 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 whole time equivalent staff working 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>39%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career&lt;sup&gt;^&lt;/sup&gt;</td>
<td>26%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group&lt;sup&gt;~&lt;/sup&gt;</td>
<td>18%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior&lt;sup&gt;*&lt;/sup&gt;</td>
<td>17%</td>
<td>11%</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)

Records
A combination of paper and electronic patient records was in place. Arrangements for the management of patient records were set out in trust policies. Compliance with the policies should be audited on a monthly basis. We saw this happened and that overall compliance with records standards from January 2017 to December 2017 ranged between 90% and 100% in all areas within the surgical division.

Trust policies stated that all records which included patient-identifiable information must be stored securely and kept strictly confidential within the establishment. We saw this to be the case and saw senior nurses remind doctors to follow this procedure before leaving clinical areas.

During our inspection we reviewed 41 sets of patient records, including nursing, therapy and medical notes, medicines administration records, operation notes and consent forms. All of the records we looked at were legible, dated and signed and maintained in accordance with national standards from the relevant professional regulators including the General Medical Council and Nursing and Midwifery Council.

Medicines
Medicines, including controlled drugs, were securely stored. Stocks of medicines and controlled drugs (CD) were checked daily by staff and we saw evidence of CD audits. CDs were in good condition and records were completed accurately. We saw correctly completed entries in the CD registers in the wards and operating theatre departments.

Temperature monitoring is a method of assuring that medicines have been stored in the correct condition and are suitable for use. Medicines that required refrigeration were stored appropriately in locked fridges. The nurses undertook daily temperature checks and all the records we saw showed the fridges were in the correct temperature range.

However, temperature checks for any of the medicines’ store cupboards or trolleys we looked at were inconsistent. Staff reported they were not aware of these checks or records and that there were no thermometers in place for such monitoring. Where the rooms felt warm, staff agreed that this was the case. We brought this to the attention of the trust chief pharmacist who told us they knew that lack of temperature monitoring was an issue that they were trying to resolve and that this was recorded on the trust risk register.

Medicines were supplied and administered in accordance with the trust policy, medicines legislation, and national standards and against a written prescription by a doctor. Staff had access to the current British National Formulary both in hard copy and on line.

Medicines reconciliation was taking place and appropriately recorded on the patients’ medicine administration record.

We saw emergency medicines that had been drawn into a syringe and labelled in advance of administration were left unattended in an anaesthetic room during the lunch period. An
anaesthetist explained the drugs were routinely drawn up in the morning and if they were not required would be retained for use in the event of an emergency in the afternoon. They told us that they were not present when the medicines were drawn up. It was explained that this practice was to save money and reduce wasting the drugs. This was against the trust medicines’ policy. The medicines were then discarded. We raised this with the trust chief pharmacist who confirmed this was against trust policy and that remedial action would be taken.

Staff could only access clinical rooms that held medicines via a secure digital key pad access. Tamper evident seals were in use for emergency medicines to ensure that they were readily available when needed and for use. We saw that regular checks of emergency medicines and equipment were carried out by staff.

We saw that nurses completed training before administering medicines and as part of ongoing professional development. This was through completing a competency framework from the point of induction training. We looked at records of the competency frameworks completed by nurses in the surgical division and saw that 15 out of 16 (88%) nurses required to complete a medicines management competency framework had done so in 2017. Nurses also received additional training for dispensing discharge packs.

NICE Quality Standard 61 recommends that people are prescribed antibiotics in accordance with local antibiotic formularies. Records we looked at confirmed that there were local protocols and formularies in place and that these were followed correctly by prescribing doctors.

In all patients’ records we reviewed staff had recorded allergies clearly and taken relevant action to ensure known allergies were acted upon.

There were systems in place to check for expired medicines and to rotate medicines with a shorter expiry date. We looked at a random sample of medicines at all the locations we visited. All the medicines we saw were within the expiry date.

**Incidents**

Senior managers within the surgery division told us that incident reporting was much improved within the last 18 months and that staff were encouraged to be open and report incidents. All staff we spoke with told us they felt confident to report incidents via the electronic reporting system and felt they had a good understanding of what and how to report. If an incident report (IR1) was raised that applied to patient care within surgery, a round table meeting was held and attended by relevant departmental managers and matrons. This was in order to gain an understanding of what had happened and to agree on shared learning.

During our visit we observed examples of incidents reported and escalated by staff from a range of disciplines who worked at different levels across the service. We saw that incidents were openly discussed with staff, patients and their relatives where applicable. Staff provided examples of where they received written and verbal feedback from incidents raised and felt this was informative.

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 November 2016 to October 2017, the trust reported four incidents classified as never
events for surgery. Three out of four of the never events were at Queen’s Hospital, and one occurred at King George Hospital. All related to a foreign object left inside a patient during surgery. We saw that for each of the four incidents a root cause analysis had been undertaken and reported upon with recommendations for corrective action. The division also undertook a peer review process, inviting surgical leads at other London trusts to review the never events alongside divisional leads and identify areas for improvement.

As a result of the investigations into the never events a lack of assurance for the counting of swabs, instruments and devices had been identified as a top risk for the surgery division in July 2017. A revised standard operating procedure was introduced, and standardised pre-printed swab boards, in line with the Association for Perioperative Practice (AfPP) recommendations, were introduced. In addition, two new practice educators for the operating theatre department were appointed as part of the recommendations.

During our inspection we observed the trust policy, standard operating procedure and AfPP guidelines for swab counts were not followed by a surgeon, which resulted in an incident. We raised this with the operating theatre matron who was able to demonstrate that the incident had been reported and escalated to the trust quality and safety team, and an investigation had been ordered.

Staff we spoke with from all levels of the organisation showed an understanding of duty of candour, when they would use it and the actions they would take. Staff were introduced to this during their induction programme as part of their corporate essential learning. Managers gave two examples of serious incidents that had occurred in the surgery division at Queen’s hospital during 2017 where duty of candour had been applied. Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.

In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2016 to November 2017. Twenty four of the 29 reported incidents related to Queen’s hospital. This table lists the types of incident as follows:

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Queen’s Hospital</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
A serious incident scrutiny group was established in 2016 run by the Chief Nurse and clinical staff to review each completed investigation. We saw the group met weekly and agreed corrective action.

**Duty of candour**

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The service had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. Staff we spoke with from all levels of the organisation showed an understanding of duty of candour, when they would use it, and the actions they would take. Staff were introduced to this during their induction programme as part of their corporate essential learning.

It is a mandatory requirement to participate in the Nosocomial Infection National Surveillance Scheme (NINSS) study of Surgical Site Infection (SSI). Nationally all trusts are expected to provide a minimum of three months Orthopaedic surveillance data of one of the Orthopaedic options (Total Hip Replacements (THR), Total Knee Replacements (TKR), Repair of Neck of Femur)

In information provided to us prior to our visit, the trust stated they had participated in surgical site infection surveillance for the past 12 months, and had a rolling programme for fractured neck of femur and a 3 month rotational programme for total hip replacement and total knee replacement. The data was collated for trauma by a ward nurse who was also the lead for infection control on her ward.

We were told the data was collated by the Community Orthopaedic Project of Essex (COPE) team nurse for total hip and knee replacements. This data was uploaded to the Public Health England website, and was provided to the trust infection control team via the divisional reporting system. The percentage number of SSI’s found from the audits is detailed below for the last 12 months (excluding July to September’s data which had not been collated).

Data showed consistently low incidence of infection for fractured neck of femur (less than 0.8 %) with no required action.

The trust reported that the data showed a rise in the number of SSIs in elective knee surgery, however following investigation locally no concerns or themes were raised to generate any conclusions or recommendations for improvement. This continues to be monitored through the trust infection prevention control meeting.

**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.

Trust wide data from the Patient Safety Thermometer showed that the trust reported 10 new pressure ulcers, 47 falls with harm and no new catheter urinary tract infections from November 2016 to November 2017 for surgery. Staff told us that there had been a significant improvement in falls reduction. The trust had achieved the target 5% reduction in falls per 1000 bed days.

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

Within surgery, data collection took place monthly. Surgical data for 2016/17 and 2017/18 was as follows:

**Falls with harm**
April 2016 - March 2017- 9 falls with harm in total.
April 2017 – March 2018 - 1 fall with moderate harm which was unavoidable at panel.

**Pressure Ulcers**
April 2016 - March 2017 there were 47 hospital acquired pressure ulcers (18 Grade 3/DTIs)
April 2017 - March 2018 there were 27 hospital acquired pressure ulcers (6 Grade 3/DTIs) 21 (78%) of these were deemed unavoidable at panel.

**Major incident awareness and training**
A major incident plan was available on the staff intranet, and associated action cards were accessible to relevant staff. This plan provided clinical guidance and support to staff on treating patients in the event of different kinds of emergency incident.

Since November 2017 the trust had called a major internal incident five times because of the volume of patients and lack of beds.

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority. All staff were aware of this.

**Is the service effective?**

**Evidence-based care and treatment**

We spoke with the quality and safety lead nurse for surgery, whose main role was leading on evidence based practice. They took over responsibility from the compliance team for disseminating NICE guidance in June 2017. Guidance was published on the last Wednesday of each month, and on the first Wednesday of each month the trust’s NICE compliance group met to review newly published guidelines. Members of the group included the lead consultants and quality and safety leads. Guidance assessment tools were then sent out to consultants who supplied evidence to support the guidance.

We reviewed 41 patient records during our visit and saw patients’ care was planned and delivered in line with evidence-based guidelines such as those published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. We saw that staff including temporary staff, were equipped with the necessary guidelines and standard operating procedures to carry out their work effectively. Policies, protocols and standard operating procedures were available on the hospital’s intranet. We saw staff used the intranet and accessed the relevant documents. Wards and departments also kept hard copies of the guiding documents so that staff could access these in the event of IT downtime. All policies we reviewed had a document owner, a date of approval and a date for review to ensure the most up to date version was referred to.

Different aspects of guidance were broken down by division and confirmation was expected that new guidelines had been disseminated. Action logs of previous meetings and monthly reports were reviewed at the meeting and at divisional level. The quality and safety lead nurse for surgery met with the divisional triumvirate and explained guidance in order to comply with NICE. Guidance was then disseminated by divisional leads.

Within the surgery division, one consultant was allocated to be the lead for NICE. Previously, compliance with NICE guidance was judged to be at 39%. This was due to lack of evidence. However, this had risen to 71% in September 2017 and in December 2017, had reached a 95% compliance rate.

Email confirmation that specialties and divisions were compliant with local policies and guidance was accepted. However, compliance was not always being recorded. We were told that some areas of compliance were registered with audit teams but it was not clear which these were or when they had been audited.

Information on progress with compliance was shared with the CCG, reported to CQRM and included in divisional performance. It was reported that engagement within the division was very good.
Nutrition and hydration

Staff used national guidance tools to assess patients’ hydration and nutrition needs that were set out in an up to date BHRUT nutrition and hydration policy. The trust collected data to inform compliance with food standards. These standards included screening of patients at risk of malnutrition using a national malnutrition universal screening tool (MUST). The MUST score was completed within 24 hours of admission, and then weekly or more frequently if necessary. If the assessed score was greater than two, nurses referred the patient to the dietitians for a review. In all of the patient records we looked at we found these were completed by staff. We saw that audits were undertaken on a quarterly basis and that with the exception of one ward all wards within the surgical division met their targets. One ward did not meet the target for October, November or December 2017 with an average of 66.6%.

A nutrition notice board was displayed on each ward to indicate special dietary requirements and highlight nutritionally at risk patients.

One patient told us: “The food is very good and the catering staff are always good at helping”. We saw that protected mealtimes allowed patients to eat their meals without unnecessary interruption. Staff assisted patients with eating and drinking or enabled their relatives to do so where appropriate.

Patients waiting for surgery were kept ‘nil by mouth’ in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff used a staggered admission process, which meant that patients were not kept nil by mouth for longer than needed. Staff followed guidance (Royal College of Anaesthesia: Raising the standards (2012)), about offering specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid.

Staff had access to snack trolleys, which they could offer to patients in between mealtimes. This helped to support patients’ nutritional intake and hydration. In the discharge lounge, we saw staff offered patients hot or cold drinks and snacks after their surgery. Staff were able to access meals and refreshments for patients’ different dietary requirements based on personal preference or cultural needs.

Patients were referred to dieticians and speech and language therapists for assessment of safe swallow reflex if required. Wards had link nurses for nutrition who attended regular meetings, shared information, and were able to offer advice to colleagues.

We saw patients on the wards and those waiting for discharge in the discharge lounge were offered refreshments at regular intervals.

Pain relief

Staff documented patients’ pain scores on their clinical observation charts. Patient on the wards told us staff managed their pain well by offering regular pain relieving medicines. We reviewed medicine administration records and found that staff administered medicines as prescribed. We did not see any omission of pain relieving medicines without a valid reason.

The trust had a specialist pain team consisting of six specialist nurses and a team leader. The pain team worked seven days a week across both hospital sites within the trust. All registered nurses could refer patients to the specialist pain team or anaesthetist if they were concerned that patients were in pain. Allied healthcare professionals and healthcare assistants reported to the registered nurses if patients complained of pain to ensure it was acted on.
Work had been completed within the surgery division for nurses and health care assistants to be able to look after a patient whose pain relief was administered via an epidural injection. This included e-learning and face-to-face training for staff on all surgery wards. At the time of our inspection, all eligible staff had completed the training. To complete the training, nursing staff completed three full pain assessments with a pain team nurse specialist and a written test.

In all of the patient notes we reviewed we saw evidence of input from the pain team, where appropriate.

**Patient outcomes**

From August 2016 to July 2017, all patients at Queen's Hospital had a higher expected risk of readmission for elective admissions than the average for England, including all three of the most common specialties as shown in the graph below.

**Elective Admissions - Queen’s Hospital**

![Graph showing elective admissions at Queen's Hospital and England's average](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

At Queen's Hospital, non-elective patents had a higher expected risk of readmission compared to the average for England.

In terms of the most common specialties, performance was mixed. General Surgery and ENT patients at Queen's Hospital had a higher expected risk of readmission for non-elective admissions than the average for England. However, for the same period, Trauma & Orthopaedics patients at Queen's Hospital had a lower expected risk of readmission for non-elective admissions than the average for England.

In the period January 2017 to December 2017 the return to theatre rate was 0.16%

**Non-Elective Admissions - Queen’s Hospital**

![Graph showing non-elective admissions at Queen's Hospital and England's average](image)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity
In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 5.8%, which was within the expected range. The 2016 figure was 5.9%.

The proportion of patients having surgery on the day of or day after admission was 61.6%, which was worse than the national standard of 85%. The 2015 figure was 58.1%.

The perioperative medical assessment rate was 82.4%, which met the national standard of 100%. The 2016 figure was 86.8%.

The proportion of patients not developing pressure ulcers was 99.1%, which falls in the top 25% of trusts. The 2016 figure was 96.7%.

The length of stay was 23.8 days, which falls in the middle 50% of trusts. The 2016 figure was 25.6 days.  
(Source: National Hip Fracture Database 2016)

In the 2016 Bowel Cancer Audit, 74.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This figure referred to services given in the year ending March 2015. This was higher than the national aggregate. The 2014 figure was 75.6%.

The risk-adjusted 90-day post-operative mortality rate was 3.6%, which was similar to the national aggregate. The 2014 figure was 0.9%.

The risk-adjusted 30-day unplanned readmission rate was 10.5%, No figure was provided for the previous year.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 48.8%, which was within the expected range. The 2013 figure was 55.4%.

Though this information came from one audit there are multiple years of service to which it refers.  
(Source: National Bowel Cancer Audit)

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.9% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2016 figure was 1.8%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 27 days, which was worse than audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was within the expected range at 4.9%. The 2015 figure was 3.9%.  
(Source: National Vascular Registry)

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 26.5%. This was higher than the national aggregate of 13.7% and was above the threshold in the audit of 20%.
In the 2016 National Emergency Laparotomy Audit (NELA), Queen’s Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 186 cases.

The Queen’s Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 159 cases.

The Queen’s Hospital, achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 121 cases.

The Queen’s Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 80 cases.

The risk-adjusted 30-day mortality for the Queen’s Hospital was within expectations, based on 186 cases.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was similar to the England average for the EQ VAS score however EQ-5D index score was worse than the average for England. For Varicose Veins, performance was mixed across the three indicators in comparison to the England average.
For hip replacements, performance was about the same as the England average.

For Knee replacements was about the same as the England average.

(Source: NHS Digital)
**Competent staff**

A practice development nurse was appointed in the surgical division in November 2017. Work had been carried out to assess the division’s practice development priorities that involved scoping competence and developing competency frameworks. There had also been some shadowing of colleagues, and secondments as part of professional development. All staff we spoke with told us they felt supported to attend training and were able to provide evidence of ongoing professional development. Nurses we spoke with had completed their NMC revalidation and felt they had been supported throughout the process. We saw a detailed induction programme for permanent and temporary staff.

From April 2017 to October 2017, 84% of staff within the surgical division had received an appraisal compared to a trust target of 85%. A breakdown of appraisal rates by staff group is below.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Number of individuals trained - Apr 17 to Oct 17</th>
<th>Sum of Number of individuals required - Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Average of Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Scientists</td>
<td>8</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>46</td>
<td>50</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>519</td>
<td>566</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>5</td>
<td>6</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>170</td>
<td>196</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>129</td>
<td>156</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>877</strong></td>
<td><strong>984</strong></td>
<td><strong>84%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Nursing teams had access to medical staff and a range of allied health professionals, and generally described good collaborative working practices between the teams. Examples included working with surgeons and anaesthetists, therapists, clinical nurse specialists, the mental health liaison team, pain team, dementia team, palliative care service, tissue viability service for patients with pressure ulcers or complex wounds, and the critical care outreach team for patients at risk of deterioration or sepsis.

During our inspection we saw regular consultant-led multidisciplinary meetings or rounds with therapists in clinical areas. A record of the treatment planned during the ward round was documented in patient records to enable a joined-up approach to assessing the range of patients’ needs and to ensure a consistent approach to ensuring assessments were regularly reviewed and kept up to date. For example, occupational therapists, physiotherapists, dietitians and speech and language therapists documented patient progress within the patient care record.

We spoke with senior nurses about ward rounds and board rounds happening at the same time which meant that a nurse or senior nurse was not available for both. We were told that nursing
non-attendance at ward rounds occurred if the board and ward round were held at the same time. Medical staff fed back any relevant information about decisions to change patient’s plans. The senior nurse told us this was not an ideal situation and they were working with the medical consultants towards a solution. There was joint working with therapy teams to identify patients awaiting discharge. The therapists and nursing staff would review every patient awaiting a rehabilitation bed and attend ward rounds to promote early intervention and discharge where possible.

Information regarding a patients’ stay in hospital including the surgical procedure undertaken and prescribed medicines was sent electronically to their GP on discharge. Patients were also given a paper copy to take home.

Nursing and medical staff told us they had a positive relationship with the pharmacy team, who they described as approachable and knowledgeable.

**Seven-day services**

Consultant surgeons and anaesthetists provided a 24-hour seven-day service across the surgical directorate. There was one consultant available at night after 11pm and there were always on call consultants. This meant that general surgery patients and orthopaedic and trauma patients were reviewed each day, and patient admission reviews and discharges could be facilitated through weekends.

There was 24 hour access to key diagnostic services including x ray and CT and an on-site radiographer available 24 hours a day. Between the hours of 11pm and 8am, the reporting radiographer was on call accessible through the switchboard.

There was physiotherapy cover in the orthopaedic and trauma and vascular surgery wards at weekends; however, occupational therapy, dietetic, and speech and language therapy services were provided from Monday to Friday only, with only a limited occupational therapy service at weekends. This meant that rehabilitation of patients was not maximised, and that patients who had surgery on Friday were not able to be mobilised as early as possible, for example. Staff expressed their frustration with this arrangement.

Staff reported a lack of access to medical staff at weekends was on the risk register but the trust was unable to recruit to posts. This impacted on patient care and could lead to delays to discharge. Information provided to us after the inspection showed that the service had identified delayed discharges from the Intensive Therapy Unit to the neurosurgery ward as a risk.

Trauma operating lists were scheduled at weekends. Senior managers within the surgery division told us that some general surgery elective procedures also took place at weekends with beds freed up for this.

There was a trust wide pain management team consisting of six specialist nurses and a team leader who worked seven days a week across both acute sites within the trust.

Clinical pharmacy services include pharmacists, technicians, and assistants covered designated wards five days per week. The service operated at weekends where the pharmacy was open between 9.00am and 3pm on Saturdays and 9am and 12pm on Sundays, with a pharmacy
discharge service available until 5pm on both days. An on call pharmacy service was available out of hours. Staff had access to emergency stocks of medicines at all times.

Staff we spoke with told us that radiography and haematology services were available out of hours seven days a week, if required.

**Health promotion**

Staff supported patients, and their relatives where appropriate, to manage their own health and wellbeing, and to maximise their independence following surgery. We saw enhanced recovery programmes that enabled patients to be actively involved in the recovery phase following surgery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation.

Patient records we looked at showed that staff in the surgical pre-assessment unit discussed eating well, exercise, relaxation, smoking cessation, and alcohol consumption and the importance of trying not to worry too much about the surgery. People who were smokers were referred to the smoking cessation services.

We saw information about the flu vaccine, signs of sepsis, and smoking cessation displayed on notice boards in public areas throughout the hospital, including waiting areas and the main atrium.

**Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)**

We found from reviewing healthcare records that patients who were to undergo procedures had engaged in discussion about their treatment and care plan, and that consent forms were signed by the clinician and the patient.

There were procedures in place for patients who were assessed as not having mental capacity to consent for procedures. Where this was the case there was a specific consent form to be used that required two doctors’ signatures.

Staff showed us three examples of referrals made for patients with deprivation of liberty safeguards where the least restrictive options were used.

Due to the way data are held on their local systems, the trust was unable to provide information about MCA/DoLS training by CQC core service or by individual hospital site. Information provided below covers the trusts ‘Surgery’ and ‘Anaesthetics’ divisions across the whole trust.

The trust set a target of 90% for completion of Mental Capacity Act and Deprivation of Liberty Safeguards training. Data supplied regarding the surgery and anaesthetics showed an average of 86% compliance.

**Is the service caring?**

**Compassionate care**

We saw nurses actively supporting patients upon admission, during their stay, and when they were ready for discharge.

Patients and relatives we spoke with consistently told us about the kindness of the staff across the surgery division. On all wards and clinical areas we visited, we heard positive comments from patients. One patient said: “the nurses are very cheerful and very caring”. Another patient told us “I
have absolutely no concerns”. One patient said, “The nurses are lovely; we have a laugh and a joke”.

Staff paid attention to maintaining patients’ dignity, privacy and respect. Doors to patients’ rooms were closed and privacy curtains were drawn when personal care or clinical examinations were carried out.

However, we saw a lack of privacy and respect during a morning bedside handover attended by 12 nursing staff on one surgical ward. Staff did not interact with any of the patients or address them by name during the handover report. Patients’ personal details were overheard by other patients in each of six bays of four, and by our inspector in the corridor, as the door to each bay was left open throughout. There was no evidence of any attempt to maintain confidentiality. We brought this to the attention of the matron who told us the staff involved were provided with feedback. They had been reminded of the principles of bedside handover, and an improvement in patient interaction privacy and confidentiality had been observed at the next two handovers.

From November 2016 to October 2017 the Friends and Family Test response rates for surgery at Queen’s hospital was 45%, which was better than the England average of 29%.

(Source: NHS England Friends and Family Test)

Emotional support

Staff we spoke with told us that they were concerned there was no dedicated counselling or psychology service available for surgical patients. The British Society of Rehabilitation Medicine Amputee and Prosthetic Rehabilitation Standards and Guidelines recommend that every centre should have a counselling service with readily available access for patients and relatives, and that
there a clinical psychologist should also be readily available to see selected patients. However, the trust told us that although there was no specific counselling service for amputees they did have access to the trust psychological and psychiatric services or referral to community services if required on discharge.

There was a bereavement service information leaflet available for family and friends in the event of a patient death. This included information on how to access the trust bereavement team and how to register the death. The leaflet also provided information on a range of support services for people to access if needed. A dedicated bereavement centre was opened at Queen’s hospital in March 2017 and included the bereavement team, chaplains and at specific times a local authority registrar.

There was a chaplaincy service and chapel available in the hospital that provided a multi-faith service for patients and their families.

Understanding and involvement of patients and those close to them

Patients we spoke with on the ward told us that they felt involved in the decision making process of their care and felt fully informed of their procedure. Patients we spoke to in day surgery had all seen their surgeon and had consented to their treatment.

Most patients knew what time their surgery was and all patients knew when they would be discharged. Patients in pre-assessment were encouraged to participate in their own pathway and planning. They felt encouraged to ask questions and were kept well informed through information leaflets.

Is the service responsive?

Service delivery to meet the needs of local people

Surgery services at Queen’s hospital had been established to meet the needs of local people. Emergency theatres were available 24 hours a day.

Services were planned in way that ensured surgical patients were allocated a surgical bed. At the time of the inspection, there were some surgical outliers. Surgical outliers are when there are not enough surgical beds, meaning surgical patients use other speciality beds. The number and location of outliers were reported at each bed management meeting at least three times a day. There were no medical outliers on the surgical wards.

Patients undergoing elective surgery were given appointments around their needs and requirements where possible. Appointments were booked via a central booking system that would contact the patient with a proposed date, patients then had the option to accept this date or request another. Staff reported where possible they would factor in the needs of the patient.

Certain surgical lists also provided staggered admissions for patients as it was felt that this would reduce the anxiety and stress of patients waiting for long periods of time in the day of their procedure.

Patient’s length of stay was lower than the England average. Between January 2017 and December 2017, the average length of stay for all surgical elective patients was 2.6 days, which is lower than the England average of 3.2 days. The average length of stay for all surgical non-elective patients was 3.9 days, which was also lower than England average of 5.1 days.
New roles had been established within the trust working under the supervision of registered nurses and medical staff, such as nursing associates and doctors’ assistants. Advanced surgical practitioners were also employed to help manage skills gaps and underwent training and assessment in advanced clinical skills including prescribing.

At pre-assessment, information packs were given to patients that included information on venous thromboembolism, anaesthetic, MRSA and fasting instructions. Packs also contained telephone numbers for further advice.

**Meeting people’s individual needs**

We found reasonable adjustments were made to take into account the needs of different people on the grounds of religion, disability, gender, or preference. Any patient with a learning disability who had been seen by the learning disability liaison nurse at the hospital was flagged on the internal electronic systems and a hospital passport would be used. This ensured that staff were aware and could make appropriate adjustments where required.

Transport services were available externally for service users with mobility problems. The booking team would provide patients with the contact details of an external transport organisation when their appointment was booked.

Religious needs of patients were also met and respected. The trust had a multi-faith chaplaincy team who provided spiritual and religious care to patients, visitors and staff. The chaplaincy services were available 24 hours a day and included on-call rotas out of hours. Staff were aware of the support available from the ‘end of life’ specialist team and of how to contact the chaplaincy team to support patients and their next of kin.

There were suitable arrangements in place for people who needed translation services where English was not their first language. Translators could be booked at the time surgery was arranged by the bookings team or by ward staff via a telephone interpreting service. Staff told us they regularly used the service and found it effective.

Information leaflets were accessible in different formats to suit patients differing needs. They could be converted to braille or large print for patients with visual impairments.

Support was available for patients with mental health needs, with staff being able to refer patients to the mental health liaison team. We saw an example of where this had happened for the care of a patient with challenging behaviour.

Staff had a good understanding of managing and helping patients living with dementia and patients with delirium. There was a specialist dementia nurse available, and staff had access to dementia link nurses on the wards for advice and support. Referrals could be made to an older person’s mental health liaison service if it was felt a patient required additional support or assessment.

There were numerous assessment processes in place that supported meeting people’s individual needs. There was good evidence of risk assessments and acting on identified risks. This included the identification of sepsis for which staff had received training.

We found whiteboards in use to signal the status of patients and to identify any individual needs such as risk of falls, sight issues, red tray use, (used as a visible indicator of vulnerable patients who needed help and support eating and drinking) and discharge dates. A clinical system was in use (vitalpac) that monitored and analysed patients’ vital signs and calculate early warning scores automatically.
Advice was available from trust learning disability nurse specialist who had a 24 hour target to review referred patients. Senior managers within the surgery division told us they were confident that staff were able to identify patients who may fit this profile.

Access and flow

In October 2017, the trust returned to reporting referral to treatment time (RTT) for the first time since 2014. Reporting had been suspended between 2014 and 2017 so that the trust could fully investigate the issue and create a robust and comprehensive recovery plan. The trust hosted a national conference about RTT to share their learning. From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery remained similar to the average for England. An extra 5000 operations and an extra 95,000 outpatient appointments had been undertaken as part of the recovery and improvement plan.

A breakdown of referral to treatment rates for surgery by specialty is below. Of these, three specialties were above the England average and four specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>Average for England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>100%</td>
<td>65.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>77.7%</td>
<td>73.3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>77.2%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>69.2%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>62.3%</td>
<td>77.1%</td>
</tr>
<tr>
<td>ENT</td>
<td>54.9%</td>
<td>64.6%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>54.4%</td>
<td>61.7%</td>
</tr>
</tbody>
</table>

The service was developing action plans to support demand and capacity. They had been unable to deliver an increase in discharge rates between 8am and 12 noon citing increased complexity of patient discharge (multiple agencies involved) as a significant challenge to improvement.

Senior managers within the surgery division told us they had planned in September / October 2017 to reduce elective clinics for December / January 2018. This was in order to free up doctors to be ward based. Extra fracture lists had also been added as part of winter pressures planning. There were meetings within the trust where the surgery division was represented and committed to the plan to manage winter pressures. We were told they had recently met to decide whether to
extend the reduction of elective clinics. In terms of winter pressures, the surgery leadership did not feel as though they had been under pressure. It was reported that the recently opened surgical assessment unit, had made a difference in managing winter pressures and had helped to keep the flow going.

Senior managers within the surgery division told us that the need for unplanned overnight beds from day surgery occurred ‘occasionally’ and was managed through operational meetings during the day. At 4pm, the operational meeting knew if any were required, which would have been highlighted during the day. A list will be known by midday and managed through systems and good contact with theatres. It was felt this was efficiently absorbed through capacity.

It was reported by staff that occasionally recovery was full due to the unavailability of beds on the ward. Management would then stop theatre activity.

A last-minute surgical cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over a two year period, shown below, the percentage of cancelled operations at the trust showed sporadic performance, and was mixed in comparison to the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Barking, Havering and Redbridge University Hospitals NHS Trust**
Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The nurse in charge of each inpatient area was supported by the senior sister or charge nurse for liaising with the bed manager and updated the bed and site team about bed status to ensure patient flow was maintained.

Bed and site meetings were held three times daily Monday to Friday, and as necessary at weekends. We observed two bed meetings during our inspection and saw that a designated surgical representative (Matron) attended and participated in discussion about bed occupancy, surgical outliers, and staffing levels and requirements.

In July 2017, day case activity was reported to be 10.8% against planned activity in the period August 2016 to July 2017. In the same 12 month period, elective surgery activity was 2% over performance, and non-elective surgery activity was 4% under performance. Outpatient first attendance was 17% under performance for the same period, which was an improvement on 19% the previous year. Outpatient follow up appointment was 1%. Variance of planned and actual surgical outpatient procedures was 32%.

The performance report for theatres for December 2018 showed that trust wide data compliance against a trust target of 92% for referral to treatment (RTT) was recorded as a 12 month rolling trend rate of 78.5%. However, it also showed the last two month average to be 86%. There were ten patients waiting over 40 weeks and three over 50 weeks.

Every elective patient received pre-assessment. Patients were directed to one of the trust’s two acute hospitals that hosted the particular speciality. Pre-assessment was generally six to eight weeks prior to surgery. Patients may have already prior received their surgery date or would be
told at pre-assessment. They were two weeks for cancer patients and six to eight weeks for other patients.

Learning from complaints and concerns

Staff reported that PALS worked well within the surgery division and now had 100% of complaints and issues responded to within their ten day target. There was a patient complaints coordinator who worked with PALS who the leadership felt worked well.

From October 2016 to September 2017 there were 177 complaints about surgery at BHRUT: 147 complaints were at Queen’s Hospital, and were dealt with within an average of 26 days. The trust took an average of 27 days to investigate and close complaints, which was in line with their complaints policy that states complaints should be closed within 25-40 working days. Staff we spoke with told us that learning from complaints was shared in staff meetings and by email.

A summary of complaints within the division by hospital site:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Queen's Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>97</td>
<td>119</td>
</tr>
<tr>
<td>Communication</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Waiting times for appointment</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Care process</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Waiting times for scans/tests</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Waiting times in OPD</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Safety - Assaults etc.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Safety - Accidents</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Care General - Nursing Midwife</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times for IP admission</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total</strong></td>
<td><strong>147</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)
Leadership

The leadership structure within the surgery division included both acute hospital sites of the trust. A triumvirate consisted of a divisional lead nurse for surgery, the divisional manager for surgery and the divisional director who was the medical lead. The divisional director attended the executive committee meetings, which was a sub-committee of the trust board. There was a deputy divisional manager and two specialty managers’ posts. One covered general surgery and urology and the other covered orthopaedic, ophthalmology, head and neck, ENT and maxillofacial surgery.

We were told both the divisional manager for surgery and the divisional director for surgery were leaving their roles in the week after our inspection. The divisional director had very recently stepped down to focus more on clinical work. At the time of our inspection, both posts remained unfilled although we were told the manager’s position was being interviewed for the following week. The divisional manager for the operating theatre department and anaesthetics was covering in the interim period.

Staff spoke positively about the nursing leadership. There was a lead nurse for surgery who was the deputy to the divisional lead nurse, and four matrons. One for urology and breast (based at King George Hospital), a general surgery matron a specialty matron, and a matron for quality and safety who worked across both hospital sites. Each ward had a ward manager and a senior charge nurse. There was also a senior nurse for urology, and a senior nurse for ophthalmology.

Staff were less positive about medical leadership. Nursing and medical told us they felt it was not as consistent and established as the nursing leadership. Staff told us that ongoing concerns regarding medical engagement and executive staff was having a negative impact that was affecting the culture, stability and development of the service. Staff also expressed concern that the medical lead for surgery was leaving with no firm succession plans.

Junior doctors told us that the junior doctor rota was not family friendly and that due to staff shortages junior doctors often exceeded the 12 hour shift, especially when covering the emergency department. Concerns had been raised about sustainability and safety with the medical director and divisional director, however there was no agreed action so far.

Vision and strategy

The trust stated in their Quality Account 2016 – 2017, that the overall strategic direction following exit from special measures was to continue to build operational resilience required for strategic change and long-term sustainability. Within this it was proposed that Queen’s Hospital became a centre of excellence for emergency, maternity and paediatric care.

From 2016, the trust was one of five NHS trusts being supported by NHS Partnership towards a health improvement programme through a lean culture of continuous improvement. The trust vision and values were revised in 2017. The overarching vision was “To provide outstanding healthcare to our community delivered with pride “as part of their strategic plan. The vision was underpinned by five key objectives: delivering high quality care, running our hospitals efficiently, becoming an employer of choice, managing our finances, and working in partnership.
These objectives were further underpinned by the trust developing "PRIDE" values (passion, responsibility, innovation, drive, and empowerment) which we saw displayed throughout the surgical service and other areas of the hospital. All staff received PRIDE training as part of induction, which raised its profile and involved understanding of how core values were relevant to each area of work. Pride values cards were attached to name badges of staff as a reminder.

Staff we spoke with knew about the partnership with the Virginia Mason Institute and the PRIDE values; however, they showed varying understanding of the trust’s vision and strategy and could not recall any consultation prior to their introduction.

**Culture**

We saw senior staff empowered individuals to challenge poor practice or where they felt safety may be compromised. For example, we saw evidence that a healthcare assistant challenged a more senior colleague about their handwashing practice and a senior nurse challenged a doctor about the security of record storage.

However, despite the work that had been done to address the safety and culture concerns following the three never events the service had experienced in 2017, there was concern that this had not been sufficiently embedded and the risk of reoccurrence remained.

The trust recognised challenges in recruiting nurses with sufficient experience and qualifications. To address this and ensure nurses were motivated to remain in the trust and develop their career, a practice development nurse had been appointed to facilitate learning opportunities to help retention of staff.

Junior doctors we spoke with described good relationships and support from registrars, consultants and nursing staff.

Staff felt well supported by the trust occupational health service, counselling services, employee assistance arrangements and a recently established self-referral to physiotherapy.

**Governance**

Following our last inspection in 2015, we recommended that the audit programme in surgery was reviewed so that internal audits were completed and implemented. Since our previous visit the arrangements had been greatly improved. However, this was not fully embedded and further work was needed.

The monitoring and completion of internal audits in the surgery division had been reviewed and were reported at the monthly quality and safety committee meetings. Staff we spoke with told us that an external independent review was commissioned and showed us the report of the review which stated that there was an uncoordinated approach and lack of systems in place to manage, monitor and report on clinical audit.

Following the review, a number of recommendations had been acted upon by the trust. A clinical audit and effectiveness strategy and a clinical audit policy were published in December 2016 to clarify roles and responsibilities. In addition, dedicated staff had been appointed to lead the implementation and monitoring of the audit programme. They included managers, an interim clinical audit manager for the trust, a divisional quality and safety matron who worked between Queen’s hospital and King George hospital, and departmentally based quality and safety leads.

However, the post holders had been in position between one and four months at the time of our inspection, which meant we were not able to fully assess their impact.
Other staff spoke positively of the appointments and were optimistic that audits would take place and learning would be shared. An annual audit programme entitled *Learning from Our Care* had been agreed by clinical audit leads, and was scheduled from January 2018 until January 2019 on a four weekly cycle. Scheduled audits included nursing documentation, falls and wristband audits, completion of safety thermometer, completion of MUST nutritional assessment scores and hand hygiene audits.

Senior nurses, therapists and managers told us that they felt there had been significant improvements in the monitoring of clinical practice through peer review and audit by staff working in other areas in the trust, as well as members of the quality and safety team. They were able to provide examples of a range of audits carried out by a range of staff; however, the reporting systems were not fully embedded and lack of learning from audits remained an identified risk on the risk register. Staff told us that they were confident audits were taking place regularly but described the audit process as ad hoc in some areas. Staff and managers also told us there was often a lack of documentary evidence to demonstrate audits had been completed. A manager told us that the trust had invested in an electronic system to ensure there was a more co-ordinated approach. This was set up on the hospital intranet in April 2017 to provide evidence of the audits completed. However, we asked to see the register and saw that no entries were recorded on the system since its introduction. The manager that showed us the system confirmed this to be the case. Staff we spoke with felt that this was partly due to a lack of training and lack of protected time to input data. Another manager told us the lack of recorded evidence was an historical issue in the trust and that paper copies of audits would be held at departmental level. We asked to see these documents and saw that this varied from department to department, and that there was still an uncoordinated approach.

Matrons and other managers from the divisional triumvirate were scheduled into a rota to conduct weekly ‘improvement walkabouts’ in clinical areas at different times of the day and night to monitor the environment and see what could be improved. We saw these had been completed every week. Examples of issues they had identified included storage of records and non-compliance with the bare below the elbow policy. We saw these issues were fed back to staff at the time who had acted upon them.

We saw each department had a ‘fit to fly’ folder which contained a range of safety checklists that were completed as part of the risk assessment and management at the start of each shift. Staff at all levels knew where to locate the folder and had participated in the checks.

An annual Quality Account report was published by the trust. Progress reports on each of the quality improvement priorities were identified and reported to the Quality Governance Steering Group, and ultimately the trust board.

**Management of risk, issues and performance**

The surgery division used a quality scorecard to assess performance and risk on a monthly basis against trust standards or targets. This was then reported in monthly divisional performance review reports for surgery and anaesthetics and included information on staffing levels, infection screening and infection rates, rates of harm free care, pressure ulcers, falls, dementia screening, and hand hygiene compliance.

The divisional quality and safety groups used this data to plan service-level capacity and staffing, and reported to the quality governance steering groups and trust board as part of the board assurance framework.
The trust used risk registers to identify and manage risks in each service area or ward. Staff we spoke with were aware of the issues for the surgery division on their local risk register. Top risks for the division were summarised in the monthly divisional performance review report as: financial, inadequate nursing skill mix and delay in access to surgical services causing failure to achieve referral to treatment targets. Risks associated with issues identified following the never events incorrect swab count procedures in theatre also featured on the risk register. Staff we spoke with identified the same issues and were aware of what was listed on the risk register. Progress reports were produced including evidence of mitigating actions. For example on Amber B and Ocean A wards the skill mix issues had been mitigated by the appointment of a professional development nurse in August 2017 to enable a programme of ward based learning and development, including a competence framework. We saw examples of this in practise.

Reducing clinical harm was a key element of the surgery division strategy. Monthly governance meetings reviewed instances of clinical harm and discussed these with the clinical commissioning group and other stakeholders. There had been a reduction in the number of falls on Amber B. No falls with harm had been reported since March 2017. Staff told us this was due to increased staff awareness, training and simulation exercises.

**Engagement**

A patient experience strategy was developed in 2016 following engagement with a cross section of the local community to help set priorities. The strategy comprised three strands: listening and responding to feedback, working with patient partners, and improving accessibility to services for people with disabilities. Four out of seven of the surgical wards across the trust achieved a score for positive patient experience of 96% consistently.

The trust engaged with patients through a newly established Patient Partnership Council. We saw a number of volunteers worked across the organisation, including a patient partner who worked across the surgical division. Staff also told us that selected patients would visit patients undergoing similar surgery, for example.

We saw evidence of consistent and regular engagement with staff in all specialties and a wide range of responsibilities. For example, weekly unit meetings, huddles, email communication and 1 to 1 meetings with line managers. Examples of issues discussed were staffing, incidents, organisational changes and learning and development events. There were separate recovery staff meetings and team brief/coffee together in the mornings.

The annual NHS staff survey continues to be recognised as an important way of ensuring the views of staff working in the trust inform local improvements and outcomes for both staff and patients. The findings of the survey are presented and considered by the trust board and the Staff Health and Wellbeing group.

The trust participated in the 2017 NHS staff survey. The survey measured how staff felt about recognition, connection and their work in line with the NHS Engagement Score. Themes identified in the 2017 surgery division at BHRUT were: lack of senior team visibility, team inclusion and effectiveness, and staff contribution not recognised. Staff and managers told us actions taken in response to these themes were: team briefings and drop in sessions with managers, improvement walkabouts, improvements in the governance structure, and the introduction of ward of the week, star of the month staff awards and terrific tickets presented to individual staff members in recognition of good practice and performance. We saw a number of terrific tickets displayed by a
range of staff including administrative staff, and that Amber B ward had recently been awarded ward of the week.

Learning, continuous improvement and innovation

Senior managers within the surgery division identified the work carried out on their first year medical trainee (FY1) educational programme as innovative working. The trust lost its FY1s in November 2016 when Health Education removed them due to concerns about the quality of training. However, they returned them in April 2017 and complimented the trust on the educational programme that was put in to place to support them.

The service had introduced a straight to test pathway for colorectal cancer assessments. The straight to test programme meant that patients who were assessed as being suitable could be given an appointment for colonoscopy or flexible sigmoidoscopy without an outpatient consultation first. This streamlined process reduced the waiting times for patients from the date of their referral until the date of their procedure and may also mean that they received treatment for cancer more quickly.

A transanal total mesorectal excision of the rectum (TME) service had been introduced, supported by four consultants who had undergone training in this procedure. TME aims to improve the clinical outcome of rectal excision and to reduce the length of stay in hospital and morbidity after surgery.
Queen’s Hospital provides maternity services to women living in the London Boroughs of Dagenham, Havering and Redbridge and the county of Essex across hospital and community settings. The maternity service lies within the Women’s and Children’s Health Division. From July 2016 to June 2017, there were 7,719 births delivered.

The service provided consultant-led and midwifery-led maternity care for high-risk and low-risk women. The labour ward has 16 delivery rooms and two theatres. The ward also hosts a dedicated bereavement suite. The labour ward included a triage area, which is a short stay area open 24 hours a day, for seven days a week.

A six-bed obstetric assessment unit allows for the monitoring of pregnant women seven days a week; this unit operates by way of an appointment system.

Women who undergo elective or emergency caesarean sections, or who developed complications before, during or after birth are supported by a team of high dependency nurses and midwives; the six-bed unit functions as a maternity high dependency and post-operative recovery area.

Women who have a straightforward pregnancy can choose to give birth at home or in the hospital’s birthing centre. The Queen’s Birth Centre, a midwife-led service, opened in January 2013 and has eight individual side rooms and a four bed post-natal area.

The service has a 22 bed high-risk postnatal ward for women and babies who require additional care and support; this ward consists of six side rooms and four bays with four beds. In addition to the high-risk post-natal ward, the service has a 24 bed low/intermediate risk post-natal ward (Coral ward); which comprises of four side rooms and five bays with four beds.

The maternity service employs community midwives, who provide care for women and their babies both during the antenatal and postnatal period and provide a home birth service. The community midwives are aligned to the local GP practices and children’s centres.

Maternity services at Queen’s Hospital comprise a total of 62 maternity beds across three wards:

- Ante Natal Ward: 16 beds
- Coral Ward (Post-Natal): 24 beds
- Post Natal Ward: 22 beds

(Source: Trust Provider Information Request – Acute sites)

From July 2016 to June 2017 there were 7,719 deliveries at the trust. A comparison of the number of births at the trust with other trusts over the most recent 12 months is shown below.
A profile of all deliveries from July 2016 to June 2017 can be viewed in the tables below.

**Table 1: Profile of all deliveries (July 2016 to June 2017)**

<table>
<thead>
<tr>
<th></th>
<th>Barking, Havering and Redbridge University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7,619</td>
<td>98.7%</td>
</tr>
<tr>
<td>Multiple</td>
<td>100</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>218</td>
<td>2.8%</td>
</tr>
<tr>
<td>20-34</td>
<td>5,917</td>
<td>76.7%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,315</td>
<td>17.0%</td>
</tr>
<tr>
<td>40+</td>
<td>269</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7,719</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

**Table 2: Gestation periods (July 2016 to June 2017)**

<table>
<thead>
<tr>
<th></th>
<th>Barking, Havering and Redbridge University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestation period</td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>444</td>
<td>5.8%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>7,173</td>
<td>93.9%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>13</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

| Total | 7,640 | 496,578 |

Source: Hospital Episode Statistics

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.

**Number of deliveries at Barking, Havering and Redbridge University Hospitals NHS Trust by quarter.**

![Bar chart showing number of deliveries by quarter]

**SOURCE:** HES - Deliveries (July 2016 - June 2017)

Numbers of deliveries each quarter were largely stable, ranging between 1,860 in 2016/17 quarter 3 to 2,040 in 20115/16 quarter 2.

The service was last inspected in 2015 when it was rated good for effective and caring, and requires improvement for safe, responsive and well-led. The service was rated requires improvement overall. Areas for improvement that were found during the last inspection including the strengthening of governance arrangements to ensure staff within foetal medicine and antenatal clinics received timely feedback from incidents. In addition, the service did not employ...
sufficient consultant obstetricians to ensure the labour ward was adequately supported.

We carried out our unannounced inspection of Queens Hospital maternity service from 23 to 25 January 2018 and again on 8 February 2018. During our inspection, we visited clinical areas within the service including the labour ward, theatres and high dependency unit, triage, the early pregnancy unit (EPU), day assessment unit, antenatal clinic, and the foetal medicine unit. We also visited the birthing centre, antenatal and postnatal wards.

We spoke with 13 women and reviewed 14 patient records. We spoke with 53 members of staff, including, hospital and community midwives, nurses, matrons, consultants, doctors, senior managers and support staff. We observed care and treatment provided within the maternity areas. We also reviewed the trust’s performance data.

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

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trust’s ‘Women and child health’ directorate across the whole trust.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, Safety and Welfare</td>
<td>118</td>
<td>127</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>116</td>
<td>127</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>112</td>
<td>127</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>112</td>
<td>127</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>524</td>
<td>529</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>523</td>
<td>529</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>520</td>
<td>529</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>520</td>
<td>529</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>519</td>
<td>529</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>453</td>
<td>465</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>513</td>
<td>529</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>62</td>
<td>64</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The target was met by nursing and midwifery staff for all applicable training courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
A comprehensive training package was available to staff. Training modules included equality and diversity, infection, prevention and control levels one and two, information governance, conflict resolution, moving and handling, adult basic resuscitation level two and newborn basic resuscitation level two.

We requested the trust to provide us data showing completion rates within the maternity service. We found that medical staff were not always meeting the trust target compliance rate at the time of our inspection. Of the essential 15 mandatory training topics, medical staff were not meeting the target for seven. This included training in resuscitation level two (adult), where the completion rate was 67.8%, and resuscitation level two (newborn) where the completion rate was 58.9% falling below the trust target of 90% for both modules.

Midwives were meeting the completion rates in all but three of the mandatory training modules: conflict resolution initial training; information governance and mental capacity act and deprivation of liberty safeguards, where compliance fell just short of the trust target.

Mandatory training was overseen by the education team that was made up of three midwives and a team leader. Midwifery and medical staff received three days of mandatory training each year. This comprised of online and face-to-face training, and one day of skills and drills training where staff practiced emergency obstetric simulations within the maternity unit setting. In addition, a programme of eLearning was in place.

The education team kept a spreadsheet of staff attendance at mandatory training. When a member of staff did not attend, they were automatically booked on to the next training availability. Where there was consistent failure to attend, an email was sent to the line manager. Line managers monitored completion of eLearning for each member of their staff team. Staff received email reminders when training needed updating.

The education team organised ‘skills and drills’ multidisciplinary training in line with the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth recommendations. This was for healthcare professionals to maintain and manage their skills in obstetric emergencies. One day of ‘skills and drills’ were provided and emergency scenarios were practiced throughout the year. Skills included maternal collapse, transfer from birth pool, and shoulder dystocia. The education team provided verbal debriefing following the skills and drills session. High-level feedback was cascaded to staff via the message of the week newsletter and the education team offered individual development where necessary.

Medical staff and midwives were required to undertake cardiotocography (CTG) interpretation as part of the mandatory training. As of December 2017, we found that medical staff were below the trust target of 95% with a compliance rate of 89% (for both acid base balance and cardiotocography training), with midwives meeting the target. Medical staff compliance had been above target from between January and August 2017 when the completion rate began to fall.

Training in the recognition, assessment, and management of sepsis was included in the trust’s mandatory training. As of December 2017, medical staff compliance with sepsis training was at 84% below the trust target of 90%. Midwife compliance was above the target at 95%. The maternity service used the trust sepsis policy to support them to manage and recognise sepsis in pregnant women. Staff we spoke to confirmed they were aware of this policy.

Medical staff were under compliant with GROW training, with growth assessment face-to-face attendance reaching 75% with a target of 100%. ELearning in GROW for medical staff had last been recorded at 24% in November 2017. We were told that this had increased to 65% in January 2018.
Some staff told us that due to heavy workload it was often difficult to complete eLearning. Staff tried to complete this during quieter work times whilst others undertook it at home. Staff that completed training in their own time were given the time back.

**Safeguarding**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Women and child health’ directorate across the whole trust.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>107</td>
<td>127</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>92</td>
<td>125</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was met by medical/dental staff for one of the three applicable safeguarding training courses.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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>521</td>
<td>526</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>510</td>
<td>529</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>0</td>
<td>3</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was met by nursing and midwifery staff for two of the three applicable training courses.
We were told that maternity staff were not required to complete Safeguarding Adults Level 3.

(Source: Trust Provider Information Request – Training tab)

We asked the trust to provide us with data on safeguarding training specific to maternity staff. The trust set a target of 90% for completion of safeguarding training. We found that medical staff had exceeded the target for both safeguarding adults level 2 and safeguarding children level 2, but were below target at 80.7% completion for safeguarding children level 3. Midwives completion rates were above the trust target for both safeguarding adults level 2 and safeguarding children level 3.

Staff we spoke with were aware of their responsibilities in protecting adults and children from harm and abuse. Staff were confident in using the processes to report a safeguarding incident. Staff would complete an electronic safeguarding form for any concerns that arose. A multi-agency referral form was completed for all women who were booked over twelve weeks.

The maternity information system contained information relating to safeguarding. If a woman attended where safeguarding concerns were known this was flagged up on the system so that staff were aware of it. The information was available to all staff including community midwives. We saw a risk assessment undertaken for one woman where concerns were raised and a safeguarding referral had been appropriately completed. This had enabled a social worker to become involved with the mother’s care.

A named safeguarding lead midwife and deputy were in post to oversee safeguarding practice within the maternity service. Where safeguarding risks were highlighted, the safeguarding midwife put a care plan in place and liaised with other agencies as appropriate. When there was a child protection plan, the service liaised closely with social services and held a review at 32 weeks gestation.

The service had a designated team of midwives to provide specialist care, support and treatment including a midwife for teenage pregnancy, perinatal mental health midwife and substance misuse midwife.

Midwives told us the safeguarding and designated midwives were always accessible and invaluable in providing advice and support when dealing with any women where concerns were raised.

Midwives we spoke with said they felt confident in identifying cases of female genital mutilation (FGM) and child sexual exploitation (CSE). This was risk assessed when women booked their pregnancy and were referred to the teenage pregnancy midwife and/or safeguarding midwife, as well as the police and social services as appropriate. The trust had up to date policies for FGM and CSE.

Staff identified women with mental health concerns at booking and referred them to the perinatal mental health team. Where unplanned mental health needs became apparent at night or during the weekend, such as acute onset postpartum depression or deterioration of known mental health concerns, support was available via the emergency department psychiatric liaison team. On the postnatal ward, high-risk women were admitted to a bay in front of the nurse’s desk for close observation.

Pregnant women were asked about their experience of domestic violence during their booking appointment. When domestic abuse was disclosed, women were offered advice and support. A
referral was made to a domestic violence advice service, or contact details given where this was declined. Where there were risks to the unborn baby a referral was made to children’s social care. An audit undertaken between January and March 2016 showed that 92% women were asked about domestic violence during their booking appointment. At December 2017, the compliance rate had improved to 97% but still not reaching the target of 100% set by the maternity service. The trust had an infant and child abduction policy in place. This detailed security arrangements and guidance on prevention of a baby induction. The education department had also undertaken a recent ‘skills and drills’ training scenario on a baby induction to maintain staff skills and knowledge in this type of emergency situation.

**Cleanliness, infection control and hygiene**

All ward areas that we visited during our inspection were visibly clean and tidy. As part of mandatory training staff undertook training in infection prevention and control, aseptic non-touch technique, and infection prevention and control level 2. Both medical staff and midwives completion rates were above the trust target of 90%.

In the twelve months prior to our inspection the maternity service had no reported cases of hospital acquired methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C-diff). The maternity service monitored postnatal readmission rates for infection. From January to December 2017 there were 50 readmissions in maternity for infection, which was equivalent to 0.6% of the total maternity admissions over that period. Data from the trust indicated that there had been three incidents of puerperal sepsis in the twelve months prior to our inspection. Women who were admitted to a ward area with an infection were provided with a side room. We saw that personal protection equipment was available for staff to wear.

On the antenatal ward a ‘cleaning matters board’ detailing the cleaning tasks patients could expect to see carried out, and a facilities management folder set out what cleaning tasks should take place. However, there were no cleaning schedules available to confirm that the cleaning had taken place each day and no checks within the toilet to indicate when they had last been cleaned.

Hand gels were readily available on the wards. However, on the antenatal ward we observed that not all midwives were using hand gels before entering the bay to examine a woman. This meant there was a potential for the spread of infection. Hand gels were available at the entrances of wards although visitors were not routinely encouraged to use them. Staff adhered to the hospital policy of being ‘bare below the elbows’ in clinical areas.

Infection control audits were carried out on a monthly basis by the infection prevention control team. We viewed the infection control audits throughout the different maternity areas over the months of November and December 2017, and January 2018. The audits included several criteria including hand hygiene, use of personal protective equipment, cleanliness and safe use of equipment, cannula use and appropriate use of catheters. Maternity areas were mainly compliant throughout the three-month period with the antenatal, labour and postnatal ward having 100% compliance. Coral ward, HDU and the birthing centre were just below maximum compliance in one of the three months where issues were raised about multiuse equipment being clean, and insertion date not being completed for cannula dressing. Results and recommendations from the audit were emailed to the ward manager to create an action plan that was reviewed during the next audit.
Hand hygiene was included within the infection control audits where availability of hand gel and staff hand washing was noted. All areas of maternity were seen to be compliant from November 2017 and January 2018. We noted that hand hygiene audit results were not displayed on the ward or in the staff area.

Sharps boxes were assembled and labelled appropriately and not overfilled. Clinical and non-clinical waste bins in all rooms were labelled correctly displaying the type of waste they were used for. Disposable curtains were in use and installation dates had been noted.

Staff offered women the influenza (flu) and pertussis (whooping cough) vaccinations after 20 weeks gestation, in line with best practice recommendations.

Information regarding women known to have an infection was available to community midwives on the electronic system.

Community midwives told us that aprons, gloves and hand gels were freely available for them to use.

**Environment and equipment**

Waiting areas and corridors were uncluttered with the workstation central and accessible for patients and visitors. A small play area was available in the antenatal clinic with some toys to entertain children.

The antenatal ward, labour ward, and postnatal ward were all on the same level and in close proximity allowing swift and easy access to all. The birth centre was on a different floor of the hospital. Managers acknowledged that it would be practical to move the birth centre to the same level to speed up any unplanned admissions to the labour ward. This might also make women feel safer, and in turn increase the use of the birth centre. Early discussions were taking place with estates about the practicality of this, although the financial implication was recognised.

Access in and out of the maternity wards was by swipe card only. Staff we spoke with were aware of and vigilant around tailgating in and out of the wards. In the labour ward, a receptionist was in post 24 hours a day for seven days a week to welcome visitors and allow access to the ward area. Discharge from the postnatal ward was through the antenatal ward exit where a receptionist was in post during the visiting hours of between 8am and 8.30pm. Women with newborn babies that had been checked and were ready to go home were issued with a discharge form to display to the receptionist, or to a midwife during out of hours, before they were able to leave the ward. This system was not in place on Coral ward (the midwife led postnatal ward) where receptionists were provided with details of women planned for discharge, and where there was any doubt, they checked with the midwife.

We looked at 95 items of equipment throughout all areas of the maternity service including blood pressure cuffs, scanners, baby weighing scales, defibrillators and breast pumps. All equipment we checked had been cleaned. The two dopplex stands we looked at had become rusty and needed replacement.

A daily equipment checklist was in operation on the labour ward where a named person would sign to show that the equipment had been checked. On the day of our inspection, we saw that the scan machine and ventouse machine had not been checked. During our return unannounced inspection on 8 February 2018, we saw that checks on that date, and checks from 4 to 6 February 2018 were incomplete. This meant we could not be assured that equipment was being checked on a regular basis.
Staff on the labour ward told us that equipment was not always readily available for them to use. For example, midwives said that they often had to spend time locating thermometers and amnihooks, which meant that care and treatment could be delayed. A consultant told us there had been recent challenges in having scrubs ready for the obstetric theatre, although this had now been resolved.

We saw that staff checked the resuscitaires in the baby check room on the postnatal wards on a daily basis, and that checks had been completed accordingly over a two-month period.

Portable appliance testing had taken place and was in date for all equipment we looked at.

The dirty utility room on the antenatal clinic was small but clean and tidy. A system was in place for the disposal of clinical waste. However, the room was also used as a storage area for sharps bins, paper hand towels, incontinence pads and disposable wipes and gloves. This is not recommended practice, as there is a risk of cross contamination.

We checked eight fire doors (six internal and two external) all of which were closed appropriately and released when the fire alarm sounded. Fire safety training was part of the annual mandatory training and face to face practical fire safety training was provided every three years.

A trip hazard in the obstetric theatres had been detected due to a cable running along the floor. Staff had identified a piece of equipment that would provide a solution, however funds were not currently available. In the meantime, the cable had been covered to reduce the hazard and it remained upon the risk register.

Community midwives carried their own baby weighing scales, blood pressure monitors and sonicaid (for monitoring the foetal heartbeat) for home visits. The equipment received portable appliance testing on an annual basis.

The home birth midwife provided birth pools for women wishing to have a water birth at home. We were told that the pools were disposed of after 25 uses to prevent the spread of infection.

Assessing and responding to patient risk

Staff undertook risk assessments at the time of booking to consider a woman’s medical and social risks. Findings from the risk assessment helped decide whether a woman would receive midwife or consultant led care during the pregnancy. Women were also referred to specialist midwives at this time where necessary. Risk was continually assessed during antenatal appointments and where additional input was required; this was recorded within the notes.

Staff completed observations for every admission to ascertain any signs of sepsis. If there were any raised suspicions that a woman was suffering sepsis then they would carry out further screening. A new sepsis bag was in use within the service and the infection control department were introducing new sepsis trolleys. Sepsis management was part of the annual mandatory training and included within skills and drills training. Staff used the modified early obstetric warning score (MEOWS) to aid the timely identification and treatment of sepsis. A sepsis screening tool was displayed throughout the maternity service to act as a reminder to staff of the signs to look out for.

The high dependency unit led on sepsis within the service. A sepsis audit was undertaken in April 2016 where good overall compliance was found although it conclude that provision of oxygen therapy and antibiotics within one hour needed improvement. The audit also recommended that sepsis be included in the mandatory training and this was now the case.

We saw that screening for venous thromboembolism (VTE) was undertaken at admission and during antenatal appointments. We looked at the most recent VTE spot check that showed that
assessments were completed for 100% of cases at booking, 90% on the labour ward and 100% on the postnatal ward. The use of thromboprophylaxis when advised at antenatal clinic was 100%.

The service had implemented elements of the Saving Babies’ Lives care bundle (NHS England, 2016), that was designed to reduce stillbirths. This included the use of symphysis-fundal height measurements from 26 weeks gestation, and advising women regarding reduced foetal movements during their booking appointments and providing related information.

Maternity staff used the modified early obstetric warning score (MEOWS) assessment to detect signs of deterioration. We saw that this was recorded within the women’s notes we viewed. A spot check of the MEOWs within notes was carried out on a monthly basis. Spot checks between October 2016 and September 2017 showed that staff were consistently using MEOWs within the notes. The latest spot check in September 2017 demonstrated that there had been low compliance with recording the NHS number, body mass index (BMI) and respiration rate. Recommendations included results to be disseminated to all staff with one to one learning where necessary.

The maternity service had a triage area that women could access 24 hours seven days a week. Women were seen after 20 weeks of pregnancy and up to 10 weeks postnatally. Triage was staffed by one core midwife and two rotational midwives, a maternity care assistant and one registrar. A band 6 midwife was present on triage 24 hours a day. Women were seen by a midwife who would use a RAG (red, amber, green) rating to ascertain how quickly they needed to be seen and by whom. Concerns were escalated to the registrar on triage and then to the consultant. The unit also received support from specialist midwives as required. The aim was to see women within one hour and for them to leave triage within two hours.

Midwives and medical staff were trained in undertaking cardiotocography (CTG) where the foetal heart rate was monitored. Staff recorded CTGs on the electronic system. We saw that CTGs were reviewed every thirty minutes, with a system of ‘fresh eyes’ in place every hour, but beforehand where there were irregularities with the recording.

On the labour ward, an obstetrician and senior midwife undertook an electronic check of CTGs each hour. Notes for review were recorded on the system. We saw the labour ward central monitoring log where review of CTGs was recorded which contained date, time, and a signature from an obstetrician and senior midwife. Comments could be included for each entry and entries where there were concerns were flagged.

The service undertook an audit of CTG monitoring between January and June 2017. The audit demonstrated that hourly CTG reviews were being undertaken regularly, however, they were not consistently carried out by both the doctor and coordinator. The service had collected data to show reasons given as to why reviews had not taken place, or where this information was missing. The same audit showed that named midwife reviews were taking place on 80% to 90% cases. However, compliance with the ‘fresh eyes’ process had declined from over 90% to less than 70% within the six month period. The audit recommendations included a further re-audit, and staff survey to highlight any learning needs.

A CTG midwife was in post to support staff and a multidisciplinary huddle open to all staff was held weekly where CTG interpretations were discussed. The day of the huddle had been moved to facilitate the attendance of medical staff.

Staff told us that introduction of the above systems and support had led to the service operating for 11 months without a CTG incident. CTG’s remained on the risk register and were reviewed every two months. The score rating had been reduced as it was considered that the likelihood of occurrence was less.
Medical staff and midwives received training in CTG monitoring. In December 2017, we found that medical staff were below the trust target of 95% with a compliance rate of 89% (for both acid base balance and cardiotocography training), with midwives meeting the target. Medical staff compliance had been above target from between January and August 2017 when the completion rate began to fall.

During our inspection, we saw that a comprehensive handover for medical staff took place followed by a ward round where all patients were discussed and then physically reviewed. An obstetric handover sheet was completed each day on the labour ward. This detailed the leaving consultant and arriving consultant, indicated where women required immediate medical attention, confirmation that the CTG review had been undertaken and high dependency unit review had occurred.

We observed a thorough team briefing before surgery took place. We saw that the WHO (World Health Organisation) surgery checklist was used correctly within the theatre. The service undertook spot checks to ensure that the WHO checklist was being followed. We saw the spot checks for February, May, June and November 2017 which showed 100% compliance.

After women had been in theatre, they recovered in the high dependency unit where they were monitored regularly. Three Band 7 nurses, one midwife and one maternity care assistant were available within the unit.

The resuscitation trolley on the antenatal clinic was shared with the gynaecology department and kept within the clinical room. A departmental rota was in place to show designated person with responsibility for checking the trolley. We checked the resuscitation trolley on the antenatal ward and found that staff had completed all daily checks within the previous three weeks. All weekly checks had taken place within the last quarter.

We checked the resuscitation trolley on Coral postnatal ward. We found that the trolley had not been checked for one shift in January 2018 and three shifts during December 2017. Weekly check records were not in order and some weeks were missing. Our findings were raised with the ward manager at the time of inspection.

During our inspection, we observed an emergency taking place within the birth centre. Staff were prompt to act and used appropriate emergency protocols. We saw the midwives working well together to safely transfer the woman from the birthing pool to the bed.

Guidelines were in place for community midwives to follow in relation to maternal collapse and neonatal resuscitation.

A local agreement was in place with the London Ambulance Service for women to be transferred to hospital if an emergency occurred during a home birth.

We looked at the trust’s emergency obstetric guidelines including postpartum haemorrhage, hypertension in pregnancy, CTG and intrapartum death management and found that they were all in date.

**Midwifery and nurse staffing**

The trust reported their staffing numbers for nurse and midwifery staff as at September 2017 for maternity as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>92.27</td>
<td>81.47</td>
<td>88%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>303.71</td>
<td>269.41</td>
<td>89%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The maternity service planned and reviewed staffing levels and skill mix using the Birth-rate plus midwifery workforce planning tool recommended by the Department of Health to ensure women received safe care and treatment at all time.

During our inspection, actual staffing levels were meeting planned staffing levels on all but one of the wards we visited. On the labour ward, 15 midwives had been planned for the shift and there were 14 midwives present. The labour ward coordinator escalated this and a midwife was moved from the birth centre to the labour ward.

Planned and actual staffing levels were displayed within all areas of the maternity unit that we visited.

From October 2016 to September 2017, the trust reported a vacancy rate for nursing and midwifery staff of 10.4% in maternity at Queen's Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

At the time of our inspection, the number of midwifery vacancies stood at 9%. The vacancy level had reached 6% prior to that and staff told us that the vacancy rise reflected the higher planned establishment. The service were currently recruiting to 26 WTE (whole time equivalent) posts. New student midwives were due to qualify in March 2018 though would not be in post until June. The service continued to recruit to substantive specialist posts.

The maternity service monitored staff turnover on their dashboard. In April 2017 midwife turnover stood at 13.08% and reduced during the year with turnover from September to December 2017 falling below the service target rate of 11% with the December rate standing at 10.48%.

Midwife staff sickness was recorded on the maternity dashboard. Sickness rates were below the service target rate of 3.5% for five of the months between April and December 2017. Peak sickness rate was 4.64% in August 2017. The matron, head of midwifery and human resources manager met monthly to monitor sickness rates. Everyone had a return to work interview. Policies were in place for short term and long-term sickness. Employee support could be accessed, including support from employee assistance. Occupational health were available to consider reasonable adjustments where necessary and each case was looked at on an individual basis.

From October 2016 to September 2017, the trust reported that 68% of vacant shifts within the maternity core service were covered by bank staff equating to an overall use of 8.4%.

Managers told us that they did not use agency staff within the service. Use of bank staff differed between the maternity areas and wards. For example, staff on the antenatal clinic told us they rarely used bank staff whereas the labour ward used bank staff to cover shifts during most weeks. Bank staff were normally staff already working within the maternity service and were aware of the protocols.

Between July 2016 and June 2017 the trust had a ratio of one midwife to every 27 births.
In 2015/16, it had been calculated that the maternity service required a 1:24 midwife to birth ratio due to the acuity of the women using the service. Approval had been given for a 1:24 midwife to birth ratio to be reached by March 2019. Managers told us that funding was in place and released once new midwives were recruited. The maternity dashboard showed the midwife to birth ratio each month, and in September 2017 a 1:28 ratio had been met, with a 1:27 ratio being reached in October and November 2017. Student midwives and staffing of the high dependency unit were not included within the ratio. Staffing remained a concern on the risk register whilst they were below the 1:24 ratio.

The service monitored the provision of one to one care women received in established labour. From April to December 2017 the maternity service achieved 100% compliance.

The service employed pathway co-ordinators who would oversee staffing within each area of maternity every two hours throughout the day and redeploy staff to different wards as required. This would include the use of specialist staff or ward matrons who were normally supernumerary. Staff who were ill reported centrally to the coordinator so that they were aware of any staffing shortages at the start of each shift. An escalation policy was in place whereby the pathway coordinator would report staff shortage to the matron who would then escalate to the head of midwifery and divisional manager. The labour ward coordinator was supernumerary in line with best practice.

The labour ward had developed a rota for two midwives to be dedicated to caesarean sections. Whilst it was recognised that it was beneficial to have midwives specifically for the caesarean list, the two midwives had been taken away from the establishment of 15 working on the labour ward. Midwives on the labour ward said they felt the loss of the two midwives in an already pressured environment.

We observed a handover that took place from the night shift to the day shift on the postnatal ward. The handover was well attended and took place in a staff area with the door closed to ensure confidentiality. Each midwife took turns to handover their own caseload providing information that could include overnight events, current observations and vital signs, infant feeding concerns, any interventions (planned or otherwise), medications received and due, whether doctor review was required, discharge plans and any safeguarding concerns. Staff appeared attentive and engaged during the handover.

Within the community, team leaders did not hold a caseload. This enabled them to cover for staff within their team when they were ill or absent due to leave.

**Medical staffing**

During the inspection, managers told us that sickness rates for medical staff within maternity were between 0.44% and 1.34%. Data provided by the trust showed a sickness rate of 0.92% for medical staff within maternity in December 2017. Sickness for medical staff was normally covered internally or by bank staff.

The trust provided data showing a vacancy rate of 3.18% and a turnover rate of 14.04% for medical staff within maternity in December 2017.

Within the maternity and gynaecology service, 24 consultants were in post. There were normally three consultants present within the maternity service during the day shift, one on the labour ward, one covering the caesarean section list and one covering antenatal and triage.
The maternity service was working to meet 122 hours consultant cover on the labour ward each week. This was monitored on the maternity dashboard and we saw that from April to August 2017, the service had achieved 122 hours cover and from September to December 2017, 112 hours were being covered.

Two medical locums had been recruited in April 2017 to assist with reaching 122 hours consultant cover on the labour ward. Other than this, we were told that locums were rarely used.

The trust had created four more consultant posts (including two locums) the previous April in an attempt to meet the 122 hours consultant cover on the labour ward. A review was to take place by the divisional director after April 2018 once they had a year's worth of data to consider patient outcomes, staff satisfaction and patient experience so that a decision regarding safe consultant cover could be made.

Consultant cover was 24 hours Monday to Thursday. On Fridays, a consult was present until 12.30 am. Weekends cover was between 8am to 6pm. A consultant was on call during out of hours. We were told that many consultants stayed on the hospital site during out of hours. Three consultants undertook exclusively obstetric work and on any given day, there was an obstetric consultant available who would be on call after 5pm. Many consultants said that they felt well supported by their colleagues.

Two middle grade doctors covered the labour ward, triage and antenatal wards. A third middle grade doctor working within gynaecology was available for escalation.

Two consultant anaesthetists with obstetric experience were available during the day. At night there were two resident on call anaesthetists supported by an on call general consultant anaesthetist. All had received obstetric training, but did not have routine labour ward sessions as part of their job plan.

The obstetric theatres had a dedicated nursing team and were therefore not reliant on the labour ward staff.

A consultant anaesthetist was available to provide treatment to women deemed high-risk with complications such as placenta accreta. The service received a high number of referrals from other hospitals for the care of high-risk women.

One consultant told us that ‘consultant of the week’ had been a good addition to the service. The post covering ante and postnatal ward rounds between Monday and Fridays. This allowed for greater continuity of care for expectant mothers and helped with recognition of deterioration and changes in condition. It also enabled more effective liaison with the labour ward in cases of failed induction, allowing for prompt and appropriate interventions.

**Records**

The maternity service used both electronic and paper records. Paper records were normally kept with the woman, except in cases where there were confidential issues, for example, complex safeguarding concerns, in which case they were kept in a locked cabinet in a clinical room that was accessed via a key pad. At no point during the inspection did we see unattended records.
Risk assessments were completed at booking. An electronic antenatal booking history was held within the notes. Records carried by pregnant women contained details of their antenatal screening results and scan findings that enabled them to be available to community midwives.

We looked at fourteen records within the maternity service all of which were legible with name and date clearly documented. In all records that we looked at all daily observation charts for mother and baby were recorded accurately and up to date. Care plans were regularly completed indicating women’s individual choices. Specific needs and requirements were outlined including social, religious, disability and mental health needs. Referrals were documented where made, for example for specialist diabetic care.

We saw that venous thromboembolism (VTE) scoring was seen within all notes that we viewed. This helps to assess when there is a risk of blood clotting.

On the postnatal ward we were told that women self-administered clexane (which helps to stop blood clotting) injections. We saw one set of notes where clexane had been administered but not signed for.

We saw that in all but one case midwives had appropriately recorded the modified early obstetric warning signs (MEOWS). This allows the early recognition of physical deterioration of women using the maternity service.

Assessments for pressure ulcer prevention and treatment, and falls prevention were carried out in all records that we viewed.

The situation, background and recommendations (SBAR) tool used for safe handover between midwives was used within the notes. This enabled the safe handover of care of a woman when moving between wards. However, we saw the most recent CRABEL audit (a method of auditing medical records) for January 2018 which highlighted that the SBAR form was not being signed by the transferring midwife, and only around 20% were signed by the receiving midwife.

Community midwives had access to women’s maternity notes during visits and completed information on the electronic record system once back in their base. This meant that they might not always have all information immediately to hand when visiting a woman and be able to make necessary referrals during the time of the visit.

Community midwives told us that they kept their own diaries with them and took them home at night. This meant there was a potential that confidential information could be lost. The service had a standard operating procedure in place for the safe storage of maternity notes, however, the safe storage of diaries was not addressed within this.

A whiteboard displayed patient information within the staff area of the labour ward. This included patient name, location on ward, relevant information, and progress. This enabled medical staff and midwives to see at a glance the situation of each woman on the labour ward at that time.

A personalised child health record (‘red book’) was completed and provided to the parents following the birth of their child to help monitor the child’s health and development.

**Medicines**

Medicines were stored securely within locked clinical treatment rooms. Medicines expiry dates were checked monthly. All unwanted medicines were returned to the pharmacy department. Controlled drugs (CDs) kept on the maternity ward were checked twice a day by two registered midwives. A safe and secure medicines storage audit and a CD audit were completed quarterly.
Emergency medicines and equipment (including an automated external defibrillator) were readily available and were checked daily and weekly as appropriate. Oxygen cylinders were full and in date.

Medicine incidents were reported via the electronic incident reporting system. Between February 2017 and January 2018 the maternity service reported 143 medicine incidents. This equated to 5.3% of the total incidents reported within the service. Medicine incidents were cascaded to staff during the daily handover.

Current, minimum and maximum fridge temperatures were recorded daily. All the readings were in range. Freezer temperatures were also recorded daily and were in the required range.

Temperature monitoring is a method of assuring that medicines have been stored at the correct temperatures and remain suitable for use. There were no room temperature records kept for any medicines storage areas. Staff reported that they were not aware of these checks or records and that there were no thermometers in place for such monitoring. The trust chief pharmacist advised that there was an automatic air-conditioning system that maintained room temperatures suitable for medicines storage. For this reason, staff were not required to keep ambient temperature records. However, whilst on inspection some of the clinical rooms where medicines were stored felt warm. The lack of temperature monitoring meant that there was no assurance that medicines stored at room temperature remained suitable for use.

Staff had access to labelled medicines packs so were able to give out medicines supplies labelled with appropriate instructions for patients to take home. This reduced the time patients spent waiting for pharmacy to dispense medicines. Only qualified midwives were allowed to give out labelled medicine packs. Staff completed daily and weekly stock checks for the labelled medicine packs. A lead midwife also completed spot checks to provide further assurance that labelled medicines were being used appropriately. Where necessary, staff could access medicines out of hours via the site manager.

Processes were in place for the management of diabetes. Blood glucose testing kits were calibrated and managed appropriately. Staff could readily access ‘hypo boxes’ for the treatment of low blood sugar levels.

All patient demographics and allergy statuses were recorded on the prescription charts.

Venous thromboembolism (VTE) risk assessments were completed and medicines/equipment for VTE prophylaxis appropriately prescribed and supplied.

A ward pharmacist visited each ward once or twice a week and checked the prescription charts and completed medicines reconciliation. We saw some evidence that medicines reconciliation was conducted on admission to the wards. The ward had a high turnover of patients, therefore it was not possible for the ward pharmacist to screen prescription charts and complete medicines reconciliation for every patient. However, ward staff had a good relationship with the pharmacist and would contact them anytime for advice.

Staff gave patients the opportunity to self-medicate if the patient was able to do so. Guidance on this practice was found within the trust’s medicine’s policy.

**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 November 2016 to October 2017, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in maternity services at Queens Hospital which met the reporting criteria set by NHS England from December 2016 to November 2017.

All of these incidents occurred at Queen’s Hospital, Romford. These were the types of incidents:

- Maternity/Obstetric incident - baby only: nine incidents
- Maternity/Obstetric incident - mother and baby: four incidents
- Maternity/Obstetric incident - mother only: four incidents
- Surgical/invasive procedure incident: one incident
- Treatment delay: one incident

(Source: Strategic Executive Information System (STEIS))

The maternity service had one maternal death in the twelve months prior to our inspection. This had been presented at the trust’s safety summit. A guideline was in place for reviewing maternal deaths. A lead midwife, obstetrician and risk lead were designated to investigate the case internally. This meant that the family would have one point of contact throughout. Following the internal review of the maternal death, a structured external review was held. Whilst the investigation team were unable to make any recommendations, which they considered would have affected the maternal death, there were areas of practice that it was thought could be improved.

Staff were aware of their responsibility to report incidents. When an incident occurred staff recorded this on an electronic incident form that was sent through to the relevant manager. The manager would investigate the incident, taking statements where necessary, and send feedback via email to the staff member involved. Patient safety alerts were sent through to matrons to disseminate to staff.

All serious incidents were sent to the risk team for investigation. Staff felt that learning from serious incidents was clear and helped to improve the safety of the service. A significant events group met twice a week for all staff to attend where potential serious incidents were discussed and escalated. This was a multidisciplinary forum attended by obstetricians, midwives, matrons, neonatologists and anaesthetists, professional midwife advocates and the head of midwifery. Serious incidents were available on the intranet for staff to read and understand lessons that had been learnt.

During the inspection we looked at two serious incident reports in detail. Both provided a comprehensive investigation into the incident, identified lessons learnt and recommended actions for implementation. Patients were involved in the reporting stage, and offered a face to face meeting following the investigation, providing them with an opportunity for any pertinent questions to be addressed.

A report was sent out to managers on a daily basis that included which incidents were open and still required investigation, actions to be put in place and closed off. The trust policy was to close
incidents within 20 days. At the time of our inspection, the maternity service had 22 incidents open over the 20-day criteria.

A safety briefing was held each week within each area of the maternity service at which lessons learnt from recent incidents were discussed. These were disseminated to all staff during handover. Incidents were discussed during team meetings and with individual staff as necessary. In addition, link meetings were held weekly where near misses and great saves were discussed. This was a multidisciplinary forum that staff from the neonatal intensive care unit attended and contributed to.

Learning from incidents were also included in ‘message of the week’, the maternity ‘risky business’ newsletter, audit newsletter and divisional newsletter.

At our last inspection, foetal medicine and antenatal screening services were not included in incident feedback. During this inspection, we found there was improvement and staff told us they now received feedback to incidents, had time to attend meetings and received the maternity newsletter.

Some staff we spoke with felt feedback from clinical incidents could be more robust. For example, we were told that sometimes equipment such as sterile forceps was not readily available in the obstetric theatres. Whilst a response was often provided that equipment would be made available in the future it was not clear how this might be managed and in what timescale. Staff told us they were happy to raise concerns where they did not consider that a response to an investigation was thorough enough.

Trends in incidents included postpartum haemorrhage, transfers from the birth centre, unplanned admissions to the neonatal intensive care unit and perineal tears. These were monitored closely by the maternity service through use of the maternity dashboard.

The number of women experiencing a postpartum haemorrhage of between 1,500 ml and 1,999 ml was being met in five of the months between April and December 2017, and rated as ‘amber’ (a concern) in four of the months. Within the same period, women experiencing a major postpartum haemorrhage of over 2,000 ml was not being met as a target of less than 1.5% in seven months but had been reached in the past two months.

The service was using stretch targets and evidence demonstrated that the levels of postpartum haemorrhage were low in comparison to other hospitals across the London region. All incidence of postpartum haemorrhage were reviewed. A rolling audit was presented in January 2018 where recommendations included updating the audit tool, organising a specific study day and updating the postpartum haemorrhage guidelines.

Stillbirths were reviewed using the national patient safety tool and discussed at the serious incident group.

The maternity service had just started their own mortality and morbidity group that met monthly and fed in to the trust mortality meetings and end of life care group. Staff presented a case at the morbidity and mortality maternity meetings to share learning with others. However, we noted that no minutes were taken at the meetings so there was no assurance staff who were not in attendance would be aware of the lessons learnt.

All staff we spoke with were aware of their duties in relation to the duty of candour and several staff were able to provide examples of when this was applied. We saw evidence of the duty of candour being carried out.
Incident reporting within the service was above the national average with 55 incidents reported per 1,000 bed days in December 2017, with low to no harm incidents making up over 80% of incidents reported. All staff we spoke with said that incident reporting was encouraged.

**Safety thermometer**

The NHS Safety Thermometer is a national initiative, a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm-free’ care. The maternity safety thermometer focuses on: perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It is a survey carried out on a single day of each month on all postnatal mothers and their babies.

Data was captured by the service to compare with the national average and consider what improvements needed to be implemented. For example, we saw that the proportion of patients experiencing harm free care from January 2017 to December 2017 was similar to the national average of 80%, and above the average in the months of April, August and December. However, during January 2018 there was a drop to 25%. No women had a maternal infection in eight months from January 2017 to December 2017, with the peak being in January 2017 at 17.4%. No women felt alone at a time that worried them in all but two months between January and December 2017.

The safety thermometer was displayed within the maternity service, however it was very small and would be difficult for members of the public to easily view information held upon it.

### Is the service effective?

**Evidence-based care and treatment**

A quality improvement midwife was in place to ensure policies and guidelines were following evidence-based guidance.

All guidelines for the maternity service could be found on the intranet and were based on the evidence-based guidelines provided by the National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG).

There was an effective system in place to ensure policies and guidelines reflected national guidance. Guidelines were reviewed every three years or before when there were new protocols introduced. A monthly meeting was held to review guidelines and their compliance with NICE. The meeting was chaired by a consultant midwife and attended by obstetricians, midwives, neonatologists and professional midwife advocates. The guideline was revised by a designated member of staff, reviewed by the guidelines group and sent to the quality and safety meeting for approval. Updated guidelines were disseminated to staff through the newsletter, ward meetings and forums.

The reduced foetal movement guidelines had recently been updated by the professional midwife advocate to provide a clear pathway for medical staff and midwives to follow with the aim of improving maternal and neonatal outcomes. The importance of foetal movement was emphasised to women during antenatal appointments.

Women at risk of gestational diabetes were referred for a glucose tolerance test in the antenatal clinic. Consultant-led clinics were available for women with diabetes. This was in line with NICE Diabetes in pregnancy: management from preconception to the postnatal period: NG 3 (last updated August 2015).
The quality improvement midwife attended the NICE compliance group on a monthly basis to keep up-to-date with any new guidelines.

The trust were taking part in wave one of the maternal and neonatal health safety collaborative programme. The programme aimed to create safe, quality care across maternity settings, with an emphasis on continuous improvement and contributing to the reduction in maternal and neonatal deaths, stillbirths and brain injuries by 2020. The maternity service was being supported to develop new skills and resources, create an improvement plan, improve quality and safety and measure the improvement data to show the impact. It was intended that learning would be shared with trusts taking part in latter waves of the programme.

Together with the East London maternity system the service had developed guidelines and practice around an outpatient non-pharmacological induction of labour. The pilot for the cook’s cervical ripening balloon had been underway since December 2017. The cook’s balloon was used to naturally and gradually help the onset of labour. As the balloon did not require any medication, a lowering of complications during labour was anticipated, as well as less pressure being placed on inpatient beds. We were told that of the cases so far there had been a 77% vaginal delivery rate, and that women had been providing positive feedback. 30 out of 39 staff had received training on use of the cook’s balloon at the time of our inspection.

Guidelines were available on the intranet for all staff to access. This included guidelines for reduced foetal movements, protection of vulnerable adults and domestic violence.

**Nutrition and hydration**

Staff offered women enough food and drink to meet their needs and improve their health. Adjustments were made for religious and cultural needs.

All women who had undergone a caesarean section (emergency and elective) received intravenous (IV) fluid to ensure they were kept well hydrated.

Staff regularly provided water for women on the maternity wards. A range of meals could be ordered from the menu including vegetarian, halal, and steamed depending on preference.

Three infant feeding midwives were based on the postnatal ward whose role was to assist staff, provide teaching and education for staff, and to support and educate mothers with infant feeding. The service had achieved stage two in the Baby Feeding Initiative (BFI) with 83% of staff being trained.

An infant feeding group was held on the postnatal ward to support mothers, and quick response codes were displayed on the ward so that women could download information and videos regarding breastfeeding.

At the time of our inspection, staff told us that breastfeeding rates were at 59%. Data provided by the trust indicated that the percentage of infants breastfeeding at six to eight weeks was 43.7% in October 2016, 40.8% in February 2017 and 30.1% in June 2017. Staff told us that breastfeeding rates on the birth centre were higher often reaching 85% due to the lack of complications during birth which allowed for quicker skin to skin contact.

Staff recognised that further work was required to increase the breastfeeding rate. Educating staff about the importance of skin to skin care, with a longer contact period between mother and baby, and documenting any issues that mothers had with breastfeeding were all issues that the service had identified to take forward.

Babies who had ‘tongue tie’ and had difficulty feeding were diagnosed by the infant feeding midwife or paediatrician. A referral was made to a community clinic for further intervention.
When a mother chose not to breastfeed then the maternity service provided 200 ml of infant formula on the labour ward and asked the woman to provide their own formula thereafter.

We looked at the kitchen where infant milk was kept on the postnatal ward. The room was visibly clean and tidy. The fridge was clean and used only to store infant milk. We saw that the milk was correctly labelled and dated.

The fridge temperature was checked and recorded on a daily basis. There were two occasions when the temperature exceeded the appropriate range. The ward manager was able to provide evidence that this had been reported to the estates department and resolved.

**Pain relief**

We saw that midwives assessed women’s pain regularly as part of their observations using the modified early obstetric warning system (MEOWS).

If a person had difficulty communicating then staff used symbols (smiling or sad faces) and gesture to parts of the body as well as looking at facial expressions to ascertain how much pain a woman was experiencing. This would be considered with the woman during antenatal appointments and included within their care plan.

Pharmacological methods of pain relief were readily available and included nitrous oxide (gas and air), opioids (such as pethidine and oral morphine) and epidural anaesthesia.

The service operated a 24-hour anaesthetist-led epidural service. The trust provided data to show that between November 2017 and January 2018 the service were meeting requests for epidurals within 30 minutes in 96% of cases.

The number of women receiving regional anaesthesia during labour and delivery was 26% in December 2017. The service had not reached their target of fewer than 20% of women receiving regional anaesthesia in the six months prior to our inspection. However, various pain relief options were available and discussed with women, and when women made the choice of an epidural this was not denied.

Non-pharmacological pain relief methods were available. Water birth rates had reached 40% of births on the birthing centre. Staff told us that on the labour ward water births made up approximately 10% of deliveries, which the service were trying to increase.

Feedback we received from women varied. Some women we spoke with said that their pain relief had been well managed. However, three women we spoke with said that they did not receive timely pain relief and did not feel that this was prioritised by staff.

Community midwives carried entonox (gas and air) to ease women’s pain during home births. In addition, pethidine could be prescribed by a GP.

**Patient outcomes**

We reviewed the audit schedule for 2017/18. The trust were participating in five national audits including MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), National Hepatitis B audit, UK Obstetric Surveillance System, National Pregnancy in Diabetes and the Baby Friendly Initiative Audit.

The maternity service schedule included 33 audits of which seven had been completed. This included audits for neonatal readmissions, MEOWS and stillbirths. Several were due to be presented in the first three months of 2018.
An audit midwife and consultant lead were in place to manage audits. The service held an audit meeting every month that medical staff and midwives attended.

The maternity dashboard detailed performance measurements including quality, maternal morbidity, neonatal morbidity, mortality, patient satisfaction and workforce. Managers told us that the targets in place were above the North Central London region. We saw that some of the targets from the previous year’s dashboard had been increased and we were told that this was to ensure that the service continually aimed high for safe quality care.

A traffic light system was used to flag performance against the agreed thresholds on the dashboard. This enabled trends to be identified and actions to be put in to place. We saw that the trust were not meeting their 0.5% target for shoulder dystocia from April to December 2017, although performance had improved to less than 1% in three of the months.

The dashboard demonstrated that targets for induction of labour and women receiving regional anaesthesia for labour and delivery (excluding caesarean section) were consistently not being met. Women with slightly higher risks such as gestational diabetes and high body mass index could be accepted under the criteria for the cooks balloon outpatient induction and this was one of the ways the service hoped to reduce their inpatient induction rate. All decisions about induction of labour were made by the consultant. An audit for induction of labour was due to be presented at the audit meeting in January 2017.

There were no grade three or four pressure ulcers within the service between April and December 2017. During the same period the service met its target of less than 2% for intensive treatment unit admissions for unplanned obstetrics in eight of the nine months.

The service was meeting its target for the number of women experiencing third and fourth degree perineal tears following vaginal delivery in seven out of the nine months between April and September 2017 with two of the months being rated ‘amber’ for both performance measures. A specific training programme was available for the repairs of perineal tears at another hospital that registrars could attend. We found that the majority of repairs were undertaken by medical staff that had completed the training.

The maternity service were not meeting the 50% target for antenatal screening of thalassaemia and sickle cell anaemia by 12 weeks and 6 days. The challenge was engaging with expectant mothers early enough to ensure bloods were taken by 10 weeks. The service were addressing the issue through community midwives engaging with GPs to ensure referrals were made early. The quality improvement midwife had reviewed the referral that was previously taking three days to process but had now decreased the time to less than a day. Community midwives were booking women in the community during evenings and weekends to improve accessibility. The trust told us that compliance had improved from 19% to 47% with the actions that had been taken. The concern was on the risk register for regular review.

Data provided by the trust showed that from 2015 and 2016 there were 34 stillbirths out of 7234 obstetric deliveries and from 2016 to 2017, there were 35 stillbirths out of 6540 births. There were no stillbirths from midwife led births.

The maternity service told us they actively engaged with the ‘Each Baby Counts’ RCOG project that raised the profile of babies at risk of harm at the time of childbirth. Between April and December 2017 the service reported no intrapartum stillbirths.
The maternity service were aiming for a 3% rate of home births. Although this had not yet been met the service had achieved their highest number of 2.3% in December 2017. Deliveries in the birth centre had varied in the nine months prior to inspection but the service had reached their target of 20% in the last two months. An increased rate of home births and deliveries in the birth centre helped to reduce the pressure on the labour ward.

From November 2017 to January 2018, there were 31 requests for a home birth with 21 women experiencing a home birth. Two women were transferred from home during the birth, one requesting an epidural and one with a retained placenta. Five women were booked for induction of labour and one woman changed hospital.

A spot check of the antenatal growth chart assessment had been completed in the maternity service in October 2017. The check sampled 54 cases and found that 70% were correctly plotted. The check found that charts were not always being completed in their entirety and a further spot check was planned in six months.

Between 1 October 2016 and 30 September 2017 the service performed 141 medical pregnancy terminations.

Consultants had undertaken a review of the case notes on the labour ward following a recent spike in caesarean section rate. The service also had a vaginal birth after caesarean (VBAC) clinic where women could see a VBAC consultant midwife to discuss their birth options.

In the 2016 National Neonatal Audit the performance at Queen’s Hospital was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

There were 69 babies born at less than 32 weeks included in this audit measure for Queen’s Hospital. 91% of these babies had their temperature measured within an hour of birth; this was below the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 162 eligible mothers identified for inclusion in this audit measure for Queen’s Hospital. 72% of these mothers were given a complete or incomplete course of antenatal steroids; this was below the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

What proportion of babies less than 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit?

There were 79 babies born at < 33 weeks who met the criteria for inclusion in Queen’s Hospital. 56% of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was below the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

From July 2016 to June 2017 the total number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.
### Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Barking, Havering And Redbridge University Hospitals NHS Trust</th>
<th>Caesarean rate</th>
<th>Caesareans (n)</th>
<th>Caesarean rate</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>Barking, Havering And Redbridge University Hospitals NHS Trust</td>
<td>11.2%</td>
<td>863</td>
<td>11.2%</td>
<td>92.8 (z=-0.6)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td></td>
<td>15.6%</td>
<td>1,205</td>
<td>15.6%</td>
<td>101.3 (z=0.1)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td></td>
<td>26.8%</td>
<td>2,068</td>
<td>26.8%</td>
<td>97.6 (z=-0.4)</td>
<td>Similar to expected</td>
</tr>
</tbody>
</table>

In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>2,068</td>
<td>26.8%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>1,082</td>
<td>14.0%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>4,559</td>
<td>59.1%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>10</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>7,719</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans  
²Includes forceps and ventouse (vacuum) deliveries  
³Inlcudes breech and normal (non assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of November 2017 the trust reported no active maternity outliers and four closed outliers.  

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.64. The comparator group was 5.19.  

(Source: MBRRACE UK)

### Competent staff

Newly qualified midwives undertook a six-month probationary period when starting with the maternity service. A preceptorship competence based pack was in place for all new starters within
the service. New midwives were inducted within each of the maternity areas to ensure they were developing the correct skills and were confident to move between wards where required. Core midwives would support newly qualified midwives throughout their preceptorship and senior midwives signed off the competencies once completed.

New midwives and doctors to the maternity unit were given an induction by the education team. The midwife induction was for two weeks and covered orientation, use of information technology, equipment and competency observation. Midwives would be supernumerary on a number of the shifts during the induction. Induction for medical staff included clinical guidelines and CTG interpretation.

Midwives rotated through each maternity area including the antenatal, labour, postnatal wards and the birthing centre every six months to ensure all skills were up-to-date and relevant. Each midwife returning to the labour ward would be given an induction to refresh their skills and be informed of new developments. Core midwives remained on the ward for two years providing a more in-depth knowledge of the area and providing support to midwives during their rotation. Matrons were also required to rotate through the maternity areas every two years.

Specialist midwife were in post for safeguarding, CTG monitoring and interpretation, substance misuse and teenage pregnancy. They provided an expert knowledge and support to midwives within these specialist fields.

All staff were required to undertake CTG training both face-to-face and online. Staff completed a CTG interpretation and online training annually. Both elements were marked by the education team and staff expected to retake either element that was not passed. Support was given to members of staff not achieving compliance.

Skills and drills was included within the mandatory training and practiced throughout the year. This included simulating emergency scenarios including postpartum haemorrhages, shoulder dystocia and baby abduction to help support staff develop their skills for real life situations. Community midwives received the same three days mandatory training as midwives within the hospital. They had skills and drills emergency scenarios undertaken within the community setting.

The maternity service had adopted the new model of midwifery supervision of Advocating and Educating for Quality Improvement (A-EQUIP). The supervisors of midwives had received appropriate training. Two professional midwife advocacies (PMAs) were in post seven days a week to provide restorative clinical supervision, personal action for quality improvement and education and development for midwives. The professional midwifery advocate provides access to weekly group supervision or one to one where necessary. Midwives could access supervision and support from the PMAs as and when required.

Teaching sessions were held each week for staff to attend that included CTG interpretation, near miss incidents and transfers to the neonatal intensive care unit as well as monthly clinical governance audit and perinatal mortality and morbidity meetings.

Community midwives were included to work within the birth centre every four weeks. This helped to maintain their skills within the hospital setting.

Midwives who worked in the birthing centre told us they did not have specific water birth training, but were taught protocols and guidelines by their peers.

A student midwife we spoke with said that they felt well supported within the maternity unit. They were able to gain support from their mentor and were visited by their link lecturer once a week.

From April 2016 to March 2017, 93% of staff within maternity at the trust had received an
appraisal compared to a trust target of 85%. A breakdown of appraisal rates by staff group is below.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Number of individuals trained - Apr 17 to Oct 17</th>
<th>Sum of Number of individuals required - Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Trust target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>102</td>
<td>110</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>502</td>
<td>530</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>126</td>
<td>145</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>733</strong></td>
<td><strong>788</strong></td>
<td><strong>93%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff received an appraisal once a year. All staff we spoke with told us they had had their appraisal. The appraisal system gave staff time to consider development opportunities, and where managers felt there were gaps in skills or knowledge referred the midwife to the education team.

**Multidisciplinary working**

Staff worked together as a team for the benefit of patients. Medical staff, nurses, midwives and other healthcare professionals supported each other to provide care. Midwives told us they felt confident in escalating care to medical staff when appropriate, and it was evident that medical staff valued the knowledge and skills demonstrated by the midwives.

Multidisciplinary meetings were held for women with pregnancy complications including fibroids, placenta accreta and multiple previous caesareans. The team had a case by case discussion to consider the best approach for each woman so as to reach the optimum outcome. We were told by medical staff that the maternity service had received a number of referrals from other hospitals as a result of their positive interventions.

A monthly meeting was held between foetal medicine and the day assessment unit to discuss any cases where abnormalities were found.

As the service were treating many high-risk maternity cases a number of joint clinics were run to meet complex care needs. These included clinics provided for mental health, endocrine, haematology and neurology/epilepsy where staff provided specialist care.

The service worked in partnership with the London Ambulance Service undertaking skills and drills in the community.

Community midwives told us that they felt part of the hospital and were integral to the maternity service as a whole. They had good working relationships with GPs and health visitors external to the trust.

**Seven-day services**

Consultant cover was 24 hours Monday to Thursday. On Fridays, a consultant was present until 12.30 am. Weekends cover was between 8am to 6pm. A consultant was on call out of hours.
Anaesthetic cover was available within the maternity service 24 hours a day, seven days a week. At night there were two resident on call anaesthetists supported by an on call general consultant anaesthetist. All had received obstetric training, but did not have routine labour ward sessions as part of their job plan.

The maternity triage unit on the labour ward was available to women 24 hours a day, seven days a week. Women (or their partners/relatives) could telephone for advice or present to the unit if they had any concerns or health issues.

The antenatal clinic was open between 8 am and 6 pm. They opened at weekends when there was demand.

The day assessment unit was open 7.30am to 6pm. Women were given an appointment to attend during that time.

The maternity ultrasound service was provided between 8am and 8pm Monday to Friday, 7am to 5pm on Saturday and 7am to 7pm on a Sunday. We were told that if an ultrasound was required out of hours this would be done by an obstetrician on the labour ward where equipment was available.

**Health promotion**

Each community midwife team ran lifestyle improvement and parent education classes for pregnant women at the weekends. Parent education classes were also run at the hospital by the parent craft coordinator and consultant midwife.

Women were asked about smoking during their booking appointment and were offered carbon monoxide testing throughout their pregnancy. Referrals were made to support services for smoking cessation where this was agreed. We saw that 81% of women who disclosed that they smoked at booking had been referred. The service had consistently met its target of less than 10% women smoking at the time of delivery in the nine months prior to our inspection.

Midwives promoted healthy eating, and had discussions with mothers about body mass index (BMI) and any associated risks during antenatal appointments. All discussions and plans were noted on the electronic system.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Women and child health’ directorate across the whole trust.

The trust set a target of 90% for completion of MCA/DOLS training. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing staff is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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 Safeguard</td>
<td>61</td>
<td>157</td>
<td>39%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
We asked the trust to provide training data specific to the maternity service. The service had a completion target of 90% for the mandatory training on Mental Capacity Act and Deprivation of Liberty Safeguards. We found that both medical and midwifery staff completion rates were below target at 76% and 88% respectively.

Medical staff advised women of the risks and benefits when obstetric procedures such as caesarean sections were being undertaken. On the records that we looked at we saw that consent forms were completed appropriately, signed, and dated by medical staff and patients.

Many of the midwives we spoke with had limited confidence and were unclear about their responsibilities under the Mental Capacity Act and Deprivation of Liberties Safeguards. Whilst midwives received training many said that they were not confident with using it in practice, however they were clear that they could make a referral to the specialist midwife for mental health when necessary.

None of the midwives we spoke with were aware of the Fraser Guideline and Gillick Competence. Gillick competency is concerned with determining a child’s capacity to consent. The Fraser guideline is used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

A specialist mental health midwife was in place and women requiring mental health support would be referred to the mental health team. We were told that the response for women was very timely. Where women required mental health support out of hours a referral was made to the emergency department psychiatric liaison nurse. However, we had mixed feedback about how quickly their response was as this would depend upon their availability at the time.

### Is the service caring?

**Compassionate care**

Staff treated women and babies with compassion. Feedback that we received from women and their birthing partners was that they felt well cared for by staff. The majority of women spoke of having a positive experience whilst at the maternity unit.

Women we spoke with said that midwives were courteous, treated them with respect, and were sympathetic to their individual needs. One woman told us, “Every midwife has put me at ease.”

We observed staff providing compassionate care, introducing themselves, and listening to women or their birthing partners when they had questions about their care.

The service received feedback from women and their partners through the Friends and Family Test (FFT) where women could give their feedback and say whether they would recommend the service to others. The FFT showed that the percentage of women who would recommend the service was similar to the England average.
Friends and family test performance (antenatal), Barking, Havering and Redbridge University Hospitals NHS Trust

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) remained steady and was generally similar to the England average.

Friends and family test performance (birth), Barking, Havering and Redbridge University Hospitals NHS Trust

From November 2016 to October 2017 the trust’s maternity Friends and Family Test (birth) performance (% recommended) remained steady and was generally similar to the England average.
From November 2016 to October 2017 the trust’s maternity Friends and Family Test (postnatal) performance (% recommended) remained steady and was generally similar to the England average.

(Source: NHS England Friends and Family Test)

Where individual comments were provided by women these were sent on to the ward manager for their attention and to consider where any changes needed to be made. Managers discussed the FFT and specific feedback at the monthly quality and safety meetings.

The trust performed similar to other trusts for 14 out of 16 questions in the CQC maternity survey 2015.

The two questions performing worse than the England average on this survey were:

- “During your labour, were you able to move around and choose the position that made you most comfortable?”
- “Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?”

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given</td>
<td>About the same</td>
<td>8.28</td>
</tr>
<tr>
<td></td>
<td>appropriate advice and support when you contacted a midwife or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position</td>
<td>Worst performing trusts</td>
<td>7.16</td>
</tr>
<tr>
<td></td>
<td>that made you most comfortable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care</td>
<td>About the same</td>
<td>9.26</td>
</tr>
<tr>
<td></td>
<td>during labour and birth, were they able to be involved as much as they</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>wanted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest</td>
<td>Worst performing trusts</td>
<td>8.17</td>
</tr>
<tr>
<td></td>
<td>or tummy) with your baby shortly after the birth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff during labour and</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>8.93</td>
</tr>
<tr>
<td>birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or</td>
<td>About the same</td>
<td>6.89</td>
</tr>
<tr>
<td></td>
<td>doctors at a time when it worried you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it</td>
<td>About the same</td>
<td>8.21</td>
</tr>
<tr>
<td></td>
<td>was taken seriously?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to</td>
<td>About the same</td>
<td>9.36</td>
</tr>
<tr>
<td></td>
<td>in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you</td>
<td>No score</td>
<td></td>
</tr>
<tr>
<td></td>
<td>got the help you needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved</td>
<td>About the same</td>
<td>8.51</td>
</tr>
<tr>
<td></td>
<td>enough in decisions about your care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated</td>
<td>About the same</td>
<td>8.98</td>
</tr>
</tbody>
</table>
Managers said that they were now working towards a more personalised experience where women would have their choices about labour and birth respected.

The infant feeding midwife acknowledged the importance of women receiving quicker and longer skin to skin contact with their baby after birth to encourage breastfeeding and the development of a bonding relationship. Staff told us that further education for midwives in relation to skin-to-skin contact was to be introduced. We saw that skin-to-skin posters were displayed on the postnatal ward.

We observed that when women used the call bell staff could quickly identify which room to attend and responded promptly to the call.

Staff used curtains to protect women’s privacy when undertaking examinations and observation on the wards. However, on the antenatal ward and in triage we saw that the curtains were not always fully drawn. This meant women’s privacy and dignity was not being respected at all times.

We saw a number of thank you cards displayed on the postnatal and labour wards. Managers informed staff of compliments that had been sent in to the service.

**Emotional support**

Women identified with a mental health diagnosis at booking were referred to the perinatal mental health team, a multidisciplinary clinic run at a nearby hospital. A specialist mental health midwife was in post and women requiring support for the onset of conditions during or shortly following pregnancy, such as postpartum depression, would be seen on the ward by the mental health team. We were told that the response for women was very timely. Where women required mental health support out of hours a referral was made to the emergency department psychiatric liaison nurse. However, we had mixed feedback about how quickly they responded, as this would depend upon their availability at the time.

A bereavement room was available for grieving families and was located at the end of the labour ward. A specific side room on the labour ward was set aside for women who were delivering...
stillbirth babies. The room was linked to the bereavement room that enabled the mother and family members to move to the room without having to go in to the corridor of the labour ward therefore avoiding the potential of hearing crying babies.

There was a bereavement team within the maternity service made up of a band 6 and band 7 midwife led by a consultant obstetrician. The team worked closely with the midwives on the labour ward to support women through pregnancy loss. There were two counsellors provided through a service level agreement, to whom mothers and their families could be referred to following bereavement.

Bereavement was a module included within the mandatory training to enable all staff to act accordingly when a baby had died.

The service also provided spiritual care and religious support for women and relatives as needed. A multi-faith chaplaincy was located close to the maternity service.

Bereaved families usually stayed up to two days within the hospital. Women were given choices in relation to funeral arrangements including hospital or home burials.

Staff signposted women and their relatives to national and local advisory groups, when required. This included charities that provide practical advice and emotional support to families who had experienced a pregnancy loss.

A safeguarding team was in place to support vulnerable women throughout their pregnancies and birth. All staff we spoke with were confident in caring for women with complex needs and who to refer them to for specialist input.

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

Women we spoke with said that they felt they had been involved in the plans and decisions around their care. Women told us they were able to express their concerns and felt their anxieties were listened to and felt reassured.

One woman said about the care she had received from the midwife on the labour ward “She (her midwife) is very caring and responds very quickly if anything is needed.”

However, one woman we spoke with told us she had not received adequate care and input from staff as she had waited for six hours following her admissions on to the antenatal ward without being assessed or being provided with any information. When a midwife finally examined her, it was too late for her to receive pain relief, as she had originally planned, during the birth of her baby. The woman’s concerns were escalated to the antenatal ward matron who was in discussion with the woman about her care.

Information was provided to expectant mothers about their pregnancy. Women told us they felt well informed and the service kept them up-to-date with screening and scan results.

Birthing partners felt involved in discussions and decisions around care, and there were facilities available for them to stay overnight.

---

**Is the service responsive?**

**Service delivery to meet the needs of local people**
Both midwifery-led and consultant-led care models were in place to meet women’s individual needs during pregnancy. There were midwifery led community hubs throughout Goodmayes, Havering, Brentwood, Dagenham, Ilford and Loxford to serve the people of these areas. Antenatal clinics were located within communities where women had their booking appointment and received antenatal care. Women who had a higher risk pregnancy were referred to the hospital antenatal clinic that was consultant led and would have regular appointments with a consultant throughout pregnancy.

A number of joint antenatal clinics were run including mental health, endocrine, haematology and neurology/epilepsy to meet the needs of the local population.

The service was commissioned for 8,000 births a year. Projected deliveries for the year ahead were 8,300 within the maternity unit, and there was an emphasis on normalising birth and moving pressure from the labour ward when it was safe to do so.

Birth choices were offered to women. These were discussed at booking and throughout antenatal appointments. Clinics were held by consultant midwives for vaginal birth after caesarean (VBAC) and tokophobia for women who were fearful of childbirth.

The maternity service were actively encouraging home births to women at low risk during pregnancy. A home birth specialist midwife was employed as part of the community midwife establishment to support mothers wishing to have their baby at home.

In line with the Better Births plan 2016, the maternity service was developing a new personalised model whereby women would see the same midwife from antenatal through delivery to postnatal care. The service was a flexible 24-hour service, which could offer evening appointments, and a woman could choose between being seen at home or the clinic. The service had started in September 2017 and seen 15 deliveries at the time of our inspection. The midwifery team were based within one community hub, and there were discussions for the model to be rolled out to other areas and include a higher risk team.

Continuity of care was maintained with a high amount of women having the same midwife through the antenatal and postnatal period. If a woman had more complex needs they would normally see an additional midwife at the hospital. The service recognised that intrapartum continuity of care was not as high, though it was hoped that the introduction of the community Hill Top Better Births team would help to address some of this imbalance.

The maternity service recognised that a high number of expectant mothers were vulnerable women and may give rise to risk concerns. A safeguarding team of midwives had been set up to have oversight of each case.

The service had engaged with the Muslim community to ensure better understanding of the needs of a woman and their family during pregnancy, birth or loss of a baby.

Managers told us they had fostered a good relationship with the maternity voices partnership (MVP), an independent advisory group made up of service users, commissioners and providers of maternity services. Representatives from the MVP were able to attend the maternity unit at any time to do a ‘walk around’ and observe the care that staff were providing. Managers held a meeting with MVP every other month where feedback was given. This often included an experience from a woman who had used the maternity service. The MVP were seeking to provide refurbishment to the bereavement room on the labour ward through charity funds to provide a more homely and comfortable atmosphere.
An emergency 24-hour helpline was available for women who had any concerns during their pregnancy. The helpline was run by band 7 midwives who would address any concerns and advise the woman to come in to triage if it was considered necessary.

From April 2016 to September 2017 the bed occupancy levels for maternity were generally higher than the average for England. The chart below shows the occupancy levels compared to the England average over the last six quarters.

(Source: NHS England)

**Meeting people’s individual needs**

Staff identified specific individual needs during antenatal care and put a plan in place, for example, where safeguarding or mental health matters were identified. Risk assessments were undertaken to ensure a person’s individual needs were being met. This information was available via the maternity electronic system.

The service provided support for women who had complex social care needs. Specialist midwives were in post for substance misuse, teenage pregnancies and mental health who offered tailored care plans. A midwife was in post specifically to help support and advise women who had a learning disability.

The maternity service served a demographically diverse population with people from a wide range of social and ethnic groups. The service provided leaflets in different languages for those whose first language was not English.

General information leaflets were available within the antenatal clinic waiting room. Staff gave specific advice leaflets to women as and when required. The ‘my pregnancy my choice’ folder provided a range of information to women attending for appointments that also included pictorial explanations.
Interpreting services could be booked where a woman’s first language was not English, and midwives had access to a telephone translation service. During the inspection midwives had raised concerns about a poor telephone signal within the maternity unit making it difficult at times to access language line. The trust informed us that the phone with the poor signal had now been removed from the service, and DECT phones were in use that provided good connection. We saw the translation and interpreting policy that set out guidelines for staff.

A task and finish group were in place to ensure the service were meeting the accessible information standard for all documentation within the maternity unit. The service had taken the recent initiative of changing the hand held notes kept by women from red to yellow with black text that were more accessible for individuals with dyslexia.

Awareness of how to book and use BSL interpreters for deaf women appeared to vary between staff with some having had a positive experience of using BSL interpreters to communicate, and other staff not being aware that this could be utilised or booked. Managers told us that staff within the maternity service had recently received training in deaf awareness.

Staff recorded any difficulties with communication at initial booking. Midwives explained that they were flexible when engaging with people who had difficulty communicating and would find words that the woman understood or use signs and gestures to establish, for example, pain levels.

Staff told us they could access bariatric equipment when required. Bariatric beds were available for use on the wards and in the theatre.

Women with multiple pregnancies were overseen by a consultant throughout their pregnancy. A foetal medicine specialist would ensure a plan was in place for each woman, with regular scans during the pregnancy and mode of delivery decided from 36 weeks.

A perinatal mental health midwife worked within the maternity service and could be accessed Monday to Friday. Mental health support was provided within a clinic at another hospital. This was a multidisciplinary clinic run by a mental health consultant, mental health midwife, substance misuse midwife and psychiatrist.

Staff referred women to a diabetes midwife if they had pre-existing or gestational diabetes. Guidance and advice was provided to ensure better outcomes for women and their babies.

A post mortem was offered in the case of all stillbirths and undertaken when agreed by the woman and her partner to help improve future pregnancy counselling for parents.

We found that disposal of foetal remains were sensitive and practical within the early pregnancy unit. Bereavement counselling could be arranged via an online referral though waiting time was usually up to two weeks.

There were arrangements for partners to stay overnight. On the antenatal ward, partners were able to stay in single rooms, as there was no capacity on the bays. Within the postnatal ward, side rooms were available and pull-out beds could be used within the bays. We saw that a contract was in place on the postnatal ward for partners to sign to ensure security.

There were no water coolers or tea/coffee facilities for women or their partners to make drinks independently. We saw that staff regularly offered hot and cold drinks to women throughout the day.

**Access and flow**

The maternity service had not closed in the twelve months prior to our inspection. The service had an escalation plan to use in times of high pressure, to ensure the maternity service remained safe and that appropriate steps were taken when closure was unavoidable.
The maternity service was not meeting their target to screen 50% women for thalassaemia and sickle cell anaemia. We were told that the service struggled to book women by 10 weeks to ensure that the appropriate tests were done. The maternity dashboard showed that from May to July 2017 the service had not met the target of making 50% bookings by 10 weeks but were meeting the target from August to December 2017. The service were engaging with GPs to and ensure a robust referral process was in place to meet the 10 week booking target and ensure the screening was completed.

The service was consistently meeting their target of booking 95% women by 12 weeks and six days between April and December 2017.

Frequency of antenatal appointments were given depending on the women’s risk and clinical needs. We were told that due to general demand and frequency with which consultants and registrars provided appointments to expectant mothers, the antenatal clinic was often overbooked.

Staff and patients were concerned about waiting times within the antenatal clinic. One woman told us she waited two hours before being seen. The service was not monitoring waiting times within the antenatal clinic.

A further appointment was sent to women who did not attend their appointment. Staff followed up a further failed attendance with a telephone call. If there were still no contact from the woman then a community midwife would be requested to make a home visit.

Women were given appointments to attend the early pregnancy unit that could be accessed seven days a week between 7.30am and 8.30pm. Referral was made through the antenatal clinic, gynaecology or GP. It offered a range of tests and treatments including quantitative human chorionic gonadotropin (HCG) blood tests to confirm pregnancy that were available the same day. The unit was run by three specialist nurses who undertook their own ultrasound scans so women did not have to wait for medical staff.

The service operated a 24-hour a day triage service on the labour ward. This meant that women with urgent health issues, such as pain, vaginal bleeding or suspected broken waters, could be reviewed. We saw that attendance at triage varied during the day. A RAG (red, amber, green) rating was used to determine how quickly a person needed to be seen and by whom. Women were to be seen by a midwife in either five, 15 or 30 minutes depending on their symptoms. The expected time to be seen by a consultant was 60 minutes.

We were provided with data by the trust that showed triage waiting times the week before our inspection took place. We found that waiting times regularly fell below the target 95% set by the service. For example, amber rated patients were seen within target by midwives on one of the seven days, and green rated patients were seen within target by obstetricians on one of the seven days. Red rated women were seen within target on two of the three days that they presented.

We were told that when consultants were late it was reported as an incident. Most consultants told us that this was rare, although one raised it as a concern with us. Medical staff had to sign each day when arriving for handover and we saw the sign in sheet for the day of our inspection. Sign in sheets were not kept by the service and managers told us that lateness was monitored and addressed by the clinical lead.

The service were considering ways of making the labour ward more efficient by moving lower risk women to the midwifery led unit. In December 2017, 137 such moves had been made taking some pressure away from the labour ward.
The day assessment unit had six bays and undertook scan reviews, blood pressure and CTG monitoring and the outpatient induction. The unit was midwife led with a registrar and consultant available if needed. The aim of the unit was to prevent inappropriate admissions.

There were different discharge pathways to follow depending on the woman’s needs and risks and we saw that staff could access the discharge guidelines on the intranet. Where a doctor considered a woman was a lower risk they would step down the discharge process to the midwife. An additional midwife had been made available on the postnatal ward between 10.30am and 6.30pm each day who helped with discharges, safeguarding cases and medicine administration. All staff indicated that this had helped with speeding up the discharge process.

Staff told us that doctor-led baby checks could sometimes be delayed prior to discharge. When this was the case, the matron would find out if a paediatrician or registrar was available and when the problem persisted, this would be escalated to the head of midwifery.

**Learning from complaints and concerns**

From October 2016 to September 2017 there were 59 complaints about maternity at Queen’s Hospital. The trust took an average of 27 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be 25-40 working days.

A breakdown of complaints by subject is below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>38</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>5</td>
</tr>
<tr>
<td>Care General - Nursing Midwife</td>
<td>4</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>2</td>
</tr>
<tr>
<td>Care process</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
</tr>
<tr>
<td>Safety - other</td>
<td>2</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times for IP admission</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>59</strong></td>
</tr>
</tbody>
</table>

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

The head of midwifery managed the complaints coming in to the maternity service. Managers initially offered a meeting to the complainant to discuss any issues face to face. Each complaint would be allocated to an appropriate member of staff for a response, which in turn was checked by the divisional director. A complaints meeting was held on a weekly basis to discuss themes, what actions were being taken and lessons learnt, and compliance with responding to complaints.

A complaints coordinator kept a database with timeframes for the complaint and actions being undertaken and this was reviewed during the monthly meeting.

The service had been compliant with responding to complaints within the set timeframes in the eight months prior to inspection.
Managers told us that a number of the complaints received by the service concerned poor communication. This was often in relation to staff not relaying information clearly or appropriately to women in emergency situations. Managers acknowledged that clearer information needed to be provided to women under these circumstances.

Themes from complaints and actions being taken would be disseminated to staff during ward meetings and at the safety briefing.

‘Good to talk’ boards were visible on the ward that displayed information on staff available to support patients, PALS information, complaints, and feedback opportunities.

**Is the service well-led?**

**Leadership**

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Managers at both senior and local levels voiced a determination for ongoing improvement within the maternity service.

The maternity service lay under the women and children’s health division within the trust. Oversight of the maternity service was via a triumvirate including the divisional director, divisional manager and director of midwifery. We interviewed the senior management team who demonstrated an awareness of the performance within the maternity service along with its challenges.

The director of midwifery’s office was on the maternity unit so that she was easily accessed by staff. All staff we spoke with said that they regularly saw the senior managers on the wards and that they felt confident to approach and discuss issues with the head of midwifery and director of midwifery.

Many frontline staff told us that board executives were rarely seen on the maternity unit, though many recalled members of the senior leadership team coming and speaking to them about the flu vaccination.

We saw strong leadership at local level with all wards and units being well managed. All grades of staff told us that managers were readily available to answer questions. One manager we spoke with said that she had received good support during the three months she had been with the maternity service, with peers and management on hand to give advice.

A lone working policy was in place that staff could access on the intranet. Community midwives had lone working devices to activate when they were in an emergency. If they had concerns about visiting an address, they would take another colleague with them and inform their manager once the visit was completed.

Managers felt it was important for staff to take ownership of the areas in which they worked and be able to speak up and suggest new initiatives. They said that they encouraged an open culture so that any concerns could be addressed promptly without blame. Staff that we spoke with said that managers had an open door policy and told us they were confident to raise concerns or new ideas.

Consultant leads were in place for specific services including the labour ward, high dependency unit and antenatal ward.

The labour ward coordinator was supernumerary for the staffing numbers required for one to one care.
A leadership programme was run for managers and staff to develop within their roles. The consensus amongst staff of all grades was that there had been ongoing improvement throughout the service, many saying that the maternity service was ‘a different place from what it used to be’. Staff felt supported by the leadership to provide high quality care to women using the service.

**Vision and strategy**

Working in partnership with another organisation, the trust had developed the PRIDE (Passion, Responsibility, Innovation, Drive and Empowerment) Way that enabled staff to make changes that were needed through the patient journey. It also provided a quality improvement methodology to review and streamline processes consistently across the hospital.

All staff were trained in the PRIDE way and signed up to the culture it embraced. Within the maternity service, there was an emphasis on local ownership and streamlining processes to make them more efficient that was being embedded in practice by the quality improvement midwife.

One senior medical member of staff told us that they considered the development and introduction of the PRIDE values had played a big role in changing attitudes and the culture of the organisation. The PRIDE values were embedded within the recruitment and appraisal process to ensure staff embraced them within their practice.

During our last inspection, the maternity service had stated its vision as meeting the commissioning arrangements of delivering 8,000 births, exceeding 15% deliveries on the birth centre and becoming a paper-light service so that midwives could spend more time providing direct care. These objectives had been met during this inspection.

The maternity service was working towards being a centre of excellence. The vision of the maternity service focused on providing high quality care for women throughout their pregnancy and birth. The focus was on the woman’s needs and involvement of women in planning to improve services.

The strategy was focused around managing the size of the labour ward, which was stretched to capacity. Senior managers were considering ways to control capacity on both a short-term and longer-term basis. Short-term measures focused upon discussions with other hospitals to redirect referrals to other areas, and the normalisation of birth to divert women from the high-risk labour ward to alternative options including home birthing and the birth centre where staff assessed this as safe. Longer-term measures that were still in discussion included looking at moving referral boundaries and expanding the maternity unit to allow for more capacity.

The service completed their first annual report for 2016/17. The report set out the top three achievements and challenges during the year, key priorities for the coming year and strategic vision over the next three years for each area of the maternity service. We saw that the strategy for the labour ward was, “Improving the awareness and facilities to achieve normalisation of birthing in a high risk acute area.”

The director of midwifery was the senior responsible officer for the maternity workstream of the Sustainability and Transformation Partnership (STP) with whom the trust were having ongoing discussions. An agreed plan was being developed to consider how the increasing birth rate could be managed safely across all areas within North East London.

The maternity service were working in partnership with five other maternity units with the East London Maternity System to develop a five-year plan. This plan was to deliver recommendations
made in the ‘Better Births’ maternal review 2016 both individually and collaboratively. This had the aim of standardising guidelines and ensuring care was of a high quality across all the services.

**Culture**

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Medical staff and midwives said they were supported by their colleagues within the service and were happy to seek out advice when necessary.

Managers encouraged an open culture of reporting incidents without attaching blame. Staff were happy to report incidents, and incident reporting within the service was above the national average. There was an emphasis on learning from incidents to provide safer care.

The service was committed to Duty of Candour and being open and apologising when something went wrong. Where an incident met the requirement of the Duty of Candour we saw evidence that the service met the regulatory requirements.

The trust had appointed a Freedom to Speak up Guardian. Most staff we spoke with were unaware of this role, but knew that there was a whistleblowing policy that they would feel willing to use when necessary. Many staff said they were happy to raise concerns with the management team.

**Governance**

The women’s and health divisional board met monthly to report on quality, safety, and performance. Senior managers were encouraging responsibility to be taken at a local level with divisional oversight.

The head of midwifery attended performance meetings within the trust. Information was fed upwards to the director of midwifery who attended trust executive committee meetings.

The director of midwifery reported to the chief nurse who was the executive lead for the maternity service. A non-executive director for maternity had not been in position for several months at the time of our inspection.

An executive meeting was held on a monthly basis at which they would discuss risks, performance, sickness and staffing. Staffing of the maternity service was regularly monitored at the meeting as the trust were commissioned for 8,000 births but the predicted number for the end of the year was 8,300.

A clinical quality review meeting for maternity was held every other month where the trust and commissioners reviewed all the quality measures.

Labour ward forums were held every month attended by the head of midwifery, matrons, consultant obstetricians, operating department practitioners, and staff from the birth centre and triage. The meetings would consider exception reports, developments, relationships between departments, and incidents.

Maternity quality and safety meetings were held every month where serious incident recommendations were discussed and the risk register actions were reviewed. Other recurring agenda items included health and safety, infection control, and safety thermometer data.
A trust wide patient safety summit was held on a monthly basis. This was a multidisciplinary forum and representatives from maternity attended to help cascade learning to other members of staff within the maternity service.

The consultant labour ward lead and director of midwifery were champions for maternity safety within the trust.

Management of risk, issues and performance

The risks for maternity lay within the Women and Health Division risk register. The risks upon the register were rated in relation to their likelihood and severity, risk owner, date of last review and next review date. The risks on the register were reflected and vocalised by staff during our inspection.

The management team within the maternity service met every month to review the risk register and actions being taken to mitigate them. We saw the terms of reference for the quality and safety group, which stated what reports were required each month and who was responsible for completing them. Serious incident recommendations, risk register review, incident review and complaints were reported on every month.

A risk management strategy was in place that took in to regard risks within the service, serious incidents, incident reporting and complaints, and set out key responsibilities. The plan was reviewed every three years and was due for renewal in May 2018.

The service had recently introduced a monthly mortality meeting. We saw that attendance had been high at the last meeting. A presentation was made in relation to a case that was sent around to staff. However, no minutes of the meeting were recorded and therefore lessons learnt that were discussed in the meeting may not be cascaded to staff. The trust also had a mortality meeting which the maternity service fed in to.

Monitoring of morbidity, mortality, key performance indicators and other significant service utility indicators was achieved using a maternity dashboard, which we reviewed as part of the inspection process.

The risk management plan was underpinned by a comprehensive schedule of audits undertaken by the maternity service. Where risks were identified, recommendations were made to improve standards and mitigate the risks.

A serious incident group met twice a week to review incidents and escalate serious incidents.

The service held link meetings each week that included attendance from the neonatal intensive care unit (NICU) and maternity service. The meeting enabled discussion around admission to NICU, as well as looking at near misses and great saves (where notable practice had been undertaken leading to a good outcome) so that learning could be implemented.

Staff attended governance meetings where new reports for example, from MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) and London Maternal Deaths Review, were reviewed and recommendations for new practice shared. We saw that over 40 staff members had attended the most recent meeting across midwifery and medical staffing.

A daily safety brief was held in each area of the maternity service whereby senior midwives and medical staff communicated risk and key information. This ensured senior staff from each area maintained an effective oversight of the daily risks of the service and this was shared with staff throughout all areas.
Information management

The maternity service had clear performance measures that were documented on the maternity dashboard. The dashboard enabled senior staff to monitor activity and clinical outcomes. The dashboard tracked monthly performance against locally agreed standards. We saw that the dashboard was reported on and discussed at the quality and safety monthly meeting, and managers were taking action to address areas where performance was not met.

The trust were participating in five national audits including MBRRACE, National Hepatitis B audit, UK Obstetric Surveillance System, National Pregnancy in Diabetes and the Baby Friendly Initiative Audit. The maternity service schedule included 33 audits of which seven had been completed. This included audits for neonatal readmissions, modified early obstetric warning scores (MEOWS) and stillbirths. Several were due to be presented in the first three months of 2018.

Engagement

The service contributed to the CQC’s national maternity survey as well as the national friends and family test (FFT) survey. Information about the Patient Advice and Liaison Service (PALS) was available in all clinical areas, and internet feedback was also gathered through the NHS Choices website.

Staff within the maternity service encouraged women and their families to provide feedback. Family and friends forms were given to women at the point of discharge so that they could give feedback in relation to the care they had received. Feedback, including specific patient comments would be discussed at the management quality and safety meetings with the aim of improvements being made. The antenatal clinic was not part of the FFT survey and the manager felt that this meant the clinic missed out on reward and recognition for the work undertaken by staff there, and missed opportunities for gathering evidence to support change and new initiatives.

Coral Ward was taking part in a NHS collaborative on real time patient experience, which provided much more detail as to what is good and what might need improvement. A baseline assessment was undertaken in December and managers felt it could provide a good source of user feedback to improve and develop services. The maternity service planned to incorporate ten questions around staff experience in to the survey to gain feedback from frontline staff.

Meetings were held every other month with the Maternity Voices Partnership that was made up of women who had used the service, commissioners, and service providers. Women contributed to the meetings, providing details of their own experience of using the maternity service. Feedback was also given following a walk around the maternity unit that might be done by a representative from the MVP at any time.

Information boards were displayed within the ward areas including planned and actual staffing for each shift that day, quality of care board that included birth activity, NICU admissions, medication incidents and complaints and feedback.

Maternity unit meetings were held every month attended by all staff including midwives, maternity support workers and porters that enabled staff to raise any concerns they may have with managers. Most staff that we spoke with said they felt confident to raise concerns with management and felt listened to. During one of these meetings, a student midwife had suggested the use of a discharge form for mothers to use when they were being discharged from the postnatal ward to increase security. This had been implemented at the time of our inspection.
As well as meeting within their teams every month, community midwives also met as a group on a monthly basis along with the community midwifery lead. Two away days were held annually specifically for community midwives to attend.

Community midwives were integrated within the main hospital maternity service. They attended the meetings at the hospital, for example, attendance at the link meeting was rotated between staff within one community team. All community midwives worked within the birth centre for one week each month and this ensured they were keeping up to date with their skills. However, some community midwives told us, and it was recognised by managers, that communication between the hospital and the community still needed improvement.

Staff were rewarded ‘terrific tickets’ by managers when they did something that went beyond their normal duties of work, which provided recognition for what they did and entitled them to a free hot drink. Message of the week included a nominated ‘star of the week’ that was presented to a member of staff. Some staff told us that whilst managers were supportive with their everyday work, when they contributed to an additional task at work, they did not feel that this was always fully appreciated and recognised.

Mentoring and coaching was available for all grades of staff and could be booked through the intranet.

Managers told us that maternity had been rated the highest in the trust for welfare during the last staff survey.

One member of staff told us that the childcare provision provided by the trust did not always have spaces available and felt that this had a negative impact upon staff retention.

**Learning, continuous improvement and innovation**

The maternity unit had achieved accreditation at stage two in the UNICEF Baby Friendly Initiative. This demonstrated that staff had the knowledge and understanding required and were working to the correct standards to support mothers with breastfeeding, and to help all parents build a secure and loving relationship with their baby.

The maternity service had been chosen as one of 11 sites to pilot the national bereavement care pathway for pregnancy and loss that was supported by the Department of Health. This involved the use of new materials, guidelines and training with the aim of improving the quality of bereavement care experienced by parents and families at all stages of pregnancy and baby loss up to 12 months.

The service were participating in research projects. One such study included the comparison of using monofilament suture material with a braided suture material on women with an insufficient cervix and examining the effect on pregnancy loss and infection rate. The research was ongoing at the time of inspection and receiving positive feedback.

The midwifery team had won team of the year at the trust’s midwifery and nursing conference and had won the runners up for the midwifery service of the year at the Royal College of Midwifery awards.

The service had developed a community team with personalised care being the main focus in line with Better Births 2016. The aim of the service was for care to be delivered by one midwife from antenatal, through intrapartum and to postnatal therefore providing continuity of care. The service was flexible, offering evening and weekend appointments and a woman could choose between being seen at home or the clinic. The service had started in September 2017 and seen 15
deliveries at the time of our inspection. The midwifery team were based within one community hub, and there were discussions for the model to be rolled out to other areas and include a higher risk team.
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.
Acute services

Urgent and emergency care

Facts and data about this service

The emergency department (ED) at King George’s hospital is open 24 hours a day seven days a week. It sees approximately 70000 patients per year with serious and life threatening emergencies, as well as treating patients with minor injuries. The hospital does not take trauma or child patients arriving by ambulance. There is also no service for gynaecology or ophthalmology patients.

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 18 years for walk in patients. Blue light ambulances did not bring children to this hospital as there was no capacity for emergency surgery at this site.

The urgent care centre (UCC) is run by another provider and is open 24 hours a day, seven days a week. This service was not part of the inspection. It was inspected in June 2017 and rated requires improvement. A clinician from the UCC streams walk-in patients into the urgent and emergency services on site. The UCC does not do blood tests or X-rays so patients requiring these are referred to ED.

The department has different areas where patients are treated depending on their needs, including a three bed resuscitation area, a 16 cubicle majors area, six ‘sub-acute’ (minors) cubicles for patients with less serious needs and a three bed clinical observation unit. A separate paediatric ED has its own waiting area.

We visited the ED over two days, 20 and 21 February 2018 during an unannounced inspection. We looked at all areas of the department and we observed care and treatment. We looked at 26 sets of patient records. We spoke with over 20 members of staff, including nurses, doctors, allied health professionals, managers, support staff, nurses from the psychiatric liaison services and ambulance crews. We also spoke with 17 patients and five relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

The CQC inspection took place during the high winter pressures across the country. This was a time of extreme pressure on all emergency departments.

Barking, Havering and Redbridge University Hospitals NHS Trust provides urgent and emergency care at both King George Hospital and Queen’s Hospital. There were 281,179 attendances from April 2016 to March 2017. The trust had some of the highest numbers of urgent and emergency care patients in England, as indicated in the chart below.
The percentage of A&E attendances at this trust that resulted in an admission increased between 2015/16 to 2016/17. In 2016/17, rates were similar to the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method:
Is the service safe?

Mandatory Training

Information provided below covers the trust’s ‘Acute Medicine’ division of which the Emergency Department is part, across the whole trust.

The trust set a standard of 90% for completion of mandatory training, and staff told us the aim was to achieve compliance with standards by the end of November 2017, but this had not been achieved.

A breakdown of compliance for mandatory courses from April to October 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>83</td>
<td>107</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>82</td>
<td>107</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>80</td>
<td>107</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>77</td>
<td>107</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

* Admitted to hospital 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)
Medical staff did not meet the training standard during that period for any of the courses. Only 66% of medical staff had completed the ‘Health, Safety and Welfare’ course at that time.

On inspection the divisional governance meeting notes indicated that compliance with mandatory training had improved, although the data we saw was not directly comparable with the CQC’s performance information request (PIR).

The trust had made 28 mandatory training modules available to locums to help ensure all ED locums were up to date with mandatory training. They were required to complete specified modules before they could start work at the trust and completion was centrally monitored.

At the last inspection there were low levels of compliance with resuscitation training, and CQC lacked assurance that locum doctors had resuscitation training. CQC had required an improvement in performance. Senior leaders had assured training standards by requiring any locum who joined the department to have their curriculum vitae (CV) approved by a substantive member of the consultant body. Locums were required to have advanced life support (ALS) or advanced trauma life support (ATLS) and paediatric life support (PLS) to work in the department. They should also be a Member of the College of Emergency Medicine (MCEM) or Fellowship of the Royal College of Emergency Medicine (FRCEM), which is achieved through examinations taken by specialists in emergency medicine. The improvement required had been achieved and we saw evidence of a continuing process to maintain this.

Nursing staff met the training standard for all applicable courses.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Moving and Handling Level 1</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>350</td>
<td>355</td>
<td>99%</td>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>Yes</td>
</tr>
</tbody>
</table>
On this inspection we found two adult nurses at this site and six paediatric nurses were awaiting basic life support updates. Managers had recently announced the dates of monthly life support courses at different levels and staff were booking training.

No children’s nurses had advanced paediatric life support training at the last inspection. National standards for children and young people in emergency care settings state that there should be someone with advanced paediatric life support (APLS) qualification on each shift. On the last inspection we found that 35% of shifts within the previous three months had not met this standard. Records confirmed that all band 5 nurses and 95% of band 6 nurses had training in intermediate life support (ILS). This followed a significant training effort in life support in 2017. We were assured that one nurse was qualified in PILS on each shift, and there was always a paediatrician with APLS as this was a requirement for working in ED at the trust. All Paediatric band 5 and 6 nurses were being funded for European Advanced Life Support training (EPALS), so all would be trained to this level by the end of 2018.

At the last inspection we found that locum doctors did not have training in sepsis management, although educational work was taking place on recognising, escalating and acting upon the signs of a potential sepsis infection. On this inspection we found sepsis management training was available to ED locum doctors. Staff were expected to complete mandatory sepsis e-learning yearly) supported by a once only mandatory face to face training session. Training rates were 87% for all ED staff in December 2017.

**Safeguarding**

There were processes, practices and systems to keep people safe from abuse. As at the previous inspection, was a high level of compliance with safeguarding training in both adults and children for nurses and staff had a good understanding of potential safeguarding issues in
relation to adults and children.

Staff were able to define triggers that would prompt them to obtain a safeguarding assessment for patients. A dedicated safeguarding lead provided support to patients and staff and helped with safeguarding referrals and patient assessments. Contact details for this member of staff were on display.

All children who attended the department were immediately assessed to identify if they might be ‘at risk’. An alert folder of children at risk was held in the emergency department. The paediatric department had access to social workers and a health visitor team within the hospital. The staff in the paediatric ED were proud of their response to safeguarding.

Paediatric staff told us the safeguarding nurse came in daily to support staff and all staff said safeguarding was well embedded in their practice. Safeguarding alerts flagged on the ED patient record system, and nurses could check the child protection register. There was a weekly safeguarding meeting. When triage or other staff raised a safeguarding alert they received feedback by email. Staff told us they attended safeguarding supervision twice a year.

Staff told us that audits of safeguarding had been valuable in increasing compliance with training. The paediatric ED had recently audited documentation on doctor’s completion of safeguarding records in patient notes. The results were not available at the time of our inspection. They also audited Multi-agency Assessment and Referral Forms (MARF). An audit was taking place of the recognition and response by ED staff to domestic violence (DV), female genital mutilation (FGM) and child sexual exploitation (CSE), through the referral pathway to the outcome for the patient. Staff were also auditing compliance with the pathway for management of mental illness for Children in ED. We observed a sensitive example of managing a teenage safeguarding case, with elements of mental health issues, while on inspection.

The safeguarding governance structure was updated in September 2017. The chief nurse was the executive lead for safeguarding, representing the trust at local safeguarding children and adult boards. The deputy chief nurse managed the safeguarding team. Named professionals within the team represented the trust at safeguarding sub groups. Safeguarding reports were shared at the trust's Quality Governance Steering Group and the Quality Assurance Committee (a sub-group of the trust board). In addition, Safeguarding Adults and Children Progress Reports were shared with the commissioners at Clinical Quality Review meetings. Safeguarding Children & Adult Annual Reports were presented to the trust board.

Information provided below covers the acute medicine directorate across the whole trust.

The trust set a standard of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
</table>
At that time, the trust met the standard for medical staff for one of the three applicable courses, scoring only 64% for the ‘Safeguarding Children Level Two’ course. Doctors’ compliance with safeguarding training had also been low at the previous inspection. However we found on our inspection that compliance had increased to 83%.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Standard (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>291</td>
<td>298</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>184</td>
<td>194</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>149</td>
<td>161</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met the standard for nursing staff for all four courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Training on FGM was mandatory. Staff also had training on CSE and on gang culture, to help identify behaviours and problems, as part of safeguarding. Staff told us the latter training had been very helpful.

**Cleanliness, infection control and hygiene**

The trust had up to date policies and procedures for hand hygiene and infection prevention and control.

The ED was visibly clean and tidy. We reviewed all patient areas as well as clean and dirty utility areas and treatment rooms.

We observed support staff cleaning the department throughout the day. Nursing staff reported that regular staff were used which meant they were familiar with the layout of the department and the cleaning requirements. Cleaning audits were undertaken to monitor cleanliness, although neither these, nor cleaning schedules were on display. Clinical staff cleaned clinical equipment.
Clean linen and equipment was stored in cupboards and a dirty utility room provided a separate area for disposing of waste. Separate clinical and general waste bins were located throughout the department. There were also bins for disposal of cytotoxic items (agents to kill or damage cells, used in cancer treatment) in majors.

Chairs in the department had plastic seats so that they could be cleaned easily.

At the last inspection we observed inconsistent handwashing practice. This had improved on this inspection. Audits for hand hygiene were carried out monthly. These showed consistently good compliance in minors and compliance averaged 97% in paediatric ED for the last three months of 2017. In adult ED the performance averaged 91%. There had been a slight decline in performance coming in the winter months as the unit became busier. However, compliance was higher than at the start of the year showing that there had been initial success in raising standards and the trust were aiming to achieve a higher level of compliance. Senior nurses told us they were working on reminders for hand washing prior to patient contact as they had identified that this was a key area where they found some staff to be non-compliant. During our visit we observed staff washing their hands and using hand gel appropriately. All clinical staff we saw were bare below the elbow.

Staff had easy access to personal protective equipment (PPE) such as aprons and gloves in all areas and we saw staff used PPE as required during our inspection. There was sufficient access to handwashing and hand sanitising facilities, which were full.

At the last inspection we had seen empty hand sanitiser dispenses and that vital signs equipment such as blood pressure monitors were not cleaned between patients. We saw staff cleaning vital signs equipment between patients.

At the last inspection we had required the hospital to ensure hazardous waste, including sharps bins, was stored according to related national guidance and European Union EU directives. On this inspection, we found that arrangements were in line with national standards including the consistent use of locked storage facilities. We did not see any overfull sharps bins. However, we saw four sharps bins that had not been labelled to show the date on which the container was assembled, or who assembled it. Sharps disposal units should be removed when three-quarters full or monthly, whichever comes first so without a label staff could not tell when to dispose of the bin.

Disposible curtains were used in the bays and we found that most were clean and stain free with a clear date of first use indicated on them.

**Environment and equipment**

There was a large shared waiting area for UCC patients and adults awaiting triage for ED. There was room for all patients and visitors to sit in this area. Staff in the reception area had good visibility of the whole waiting area, including the entrance and there was always a streaming doctor or nurse in this area as well as reception staff. The team would be able to spot any patient who might be deteriorating.

Children who were streamed to paediatric ED waited in a separate waiting area which had audio and visual separation from the adult waiting area. This was a bright, stimulating environment with distractions and entertainment for children. 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. The children’s ED had nine cubicles including a high dependency cubicle for a child who had been ‘stepped down’ from resuscitation but still needed observation. The paediatric resuscitation trolley was in this bay. The trolley was correctly stocked. Regular checks were
carried out which included twice daily checks of supplies and a weekly opening of the trolley drawers to check for out of date drugs.

In majors and minors there were central workstations with multidisciplinary working.

The main ED had 16 majors’ bays, including one bay which could be used as a high dependency bay or as an additional resus bay, facing the nursing station. There were three isolation rooms, two with doors and one with curtains. There were three consultation rooms. There was a three bay resuscitation unit with good sized bays, and one bay had equipment for both adult and paediatric resuscitation. We saw that daily checks were made of resuscitation trolleys and equipment.

There was a seated area where some patients waited for assessment and treatment, and where people waited for test results prior to discharge.

A three bed clinical observation ward was adjacent to majors and staffed by the ED. This provided a short stay, single sex facility for patients awaiting test results, requiring overnight observation or needing social services support for discharge. This also could be used to reduce late discharges home of elderly patients. Most patients stayed only one night.

In the area where patients with less serious injuries and illnesses were treated, the ‘minors’ area, there were six cubicles and one treatment room, and a seating area where people waited to be seen after triage.

One room in the ED was designated for patients with mental health needs requiring assessment or treatment and met the standards set out by the psychiatric liaison network. It had been designed to prevent the patient harming themselves or others. Two doors to the room opened outwards and could not be locked from the inside or outside, and there was a viewing window to monitor a patient using the room. Furniture was secured to the ground and there were no ligature points in the room.

There was a robust system of checklists to check that equipment was working and consumables were available. Most checklists were fully completed from 5 to 18 February 2018. However, we saw from incident forms that when short of staff or when the volume of patients was high, the checklists were not always completed. Our inspection took place in an exceptionally busy week, and we saw some gaps in checklist completion because of the pressure on the department. Resuscitation trolleys were checked daily.

A plaster application room was located between minors and majors. Plastering was carried out by nurses or accident department assistants (ADAs).

Assessing and responding to patient risk

Patients accessed the ED independently or by ambulance.

Ambulances took patients to a separate entrance, which had direct access to the resuscitation area if they required immediate treatment. The ambulance service called the hospital in advance for these cases and staff were aware of their arrival so could plan to receive them.

Less critically ill patients arriving by ambulance initially waited in a short corridor and were transferred to a bay for triage. (Triage is the process of determining the priority of patients’ treatments based on the severity of their condition). The triage nurse took a full set of observations: temperature, heart rate, respiratory rate, blood pressure, and where relevant an ECG, blood tests, a risk assessment for blood clots in the vein, and an assessment of pain, and
skin integrity including for risk of pressure ulcers. There was no triage nurse assigned to assess the patients waiting on ambulance trolleys as they came into ED, which would have started investigations and managed patient comfort earlier. However, we never saw more than three patients waiting after being taken from an ambulance at any one time, and the waits were under half an hour for these patients. Following the triage nurse assessment, patients were seen by a doctor in order of priority based on their assessment score.

Patients arriving independently had a quick initial assessment by a clinician from the co-located UCC to stream them to the GP or to the paediatric ED (for children under 16) or to the adult ED. Patients (or their carers) were given a card showing where they were streamed: yellow to paediatric ED, blue to minors and red to majors or a white card to the GP service. Patients showed the card on registration, which took place after the clinical assessment. Any child or adult considered by the streaming clinician to be very unwell could be referred direct to paediatric ED or majors with registration being done later. This meant the sickest patients went through the system without delay. Patients assessed as requiring ED treatment then registered at the ED reception and waited for assessment by a triage nurse, usually band 6.

We observed a prompt response to an emergency call for an adult who deteriorated in the waiting room.

The hospital used the National Early Warning Scoring System (NEWS) which is based on a simple 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. At the last inspection we had observed inconsistent recording of NEWS scores adults and poor calculation of scores. An audit of national early warning scores in January 2018 showed that a full set of observations was completed for 90% of the sample and 90% were accurately calculated. We reviewed 26 sets of patient records at this site during the inspection. National early warning scores had been completed for all patients. NEWS scores were audited monthly.

Staff in the paediatric ED used an age appropriate paediatric early warning score to assess deterioration and all eight records we viewed had age appropriate charts completed. Nurses were proud of their ability to spot a deteriorating child. We had no concerns on the monitoring of children's vital signs.

The last inspection had identified poor compliance on assessing the risk of venous thromboembolism (VTE), (a condition where a blood clot forms in the vein), but on this inspection we saw VTE assessments were completed. Patients suspected of having a deep vein blood clots were assessed in the minors' area.

Staff also assessed all patients in majors who met the assessment criteria for a falls risk and this assessment highlighted patients who required lying, standing, sitting BP checks. Up to a third of elderly people suffer a sudden drop in blood pressure standing up from a lying or sitting position, which can be lead to falls. The results of falls assessments were on display and showed good compliance with assessing falls risk in relevant patients.

Children who had sustained burns had a senior paediatric doctor assess them to exclude any child protection issue. Doctors could refer photographs of injury to the telemedicine referral portal system (TRIPS), a centralised system where burns specialists from the London and South East network could review pictures day and night and give advice to clinicians.

Nursing staff took action to mitigate risks of pressure ulcers (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) All patients expected to be in the department for more than a couple of hours were transferred from trolleys onto beds and pressure relieving mattresses were available as required.
At the previous inspection we had concerns about the response to patients with suspected sepsis, and only 38% of such patients had antibiotics within an hour. Sepsis management was a focus of the trust. If the triage nurse suspected sepsis this was flagged on the IT system which triggered the nurse in charge to follow the sepsis assessment plan. A sepsis screening tool and a standard treatment pathway was used in all clinical areas. Two trolleys containing the essential equipment for managing sepsis were available for easy access within the department if required so that patients could be treated promptly. Patient’s initial assessment forms had a sepsis screening box on the front that staff completed at triage or ambulance handover.

On inspection we saw staff audited ED’s sepsis performance fortnightly and teams received immediate feedback on their performance and areas for improvement. Results were discussed formally at the monthly ED quality & safety governance meeting. We reviewed audits which showed good compliance with sepsis screening 98-100%, and with administering antibiotics within an hour. In other areas of sepsis management the department performed above the national average. NHS England had recently commended the trust for being one of those that had seen the greatest improvements in performance in assessing and treating sepsis within its emergency departments. The trust was undertaking more work, in line with a national CQINN (a commissioning for quality and innovation target) which makes a proportion of healthcare providers' income conditional on demonstrating improvements in specified areas of patient care.

In line with trust policy, 16 and 17 year olds were normally treated in adult ED. We saw reminders to staff about the importance of carrying out safeguarding reviews for these young people. The safeguarding lead said they worked closely with schools pastoral care services to ensure that vulnerable young people received the appropriate support.

The method of capturing patients with mental health needs was through the Symphony tracking system in ED. Patients were categorised as a P1 – P4 depending on clinical need and this enabled a colour code of the patients name on the system to indicate this for all staff information. This was backed up by a verbal handover ensuring that any special needs that were not denoted by the category system were flagged. Staff told us they would speak to the nurse in charge when patients attended with mental health needs because the patient might have additional risk factors such as self-harm. However, nurses were not specifically trained in mental health triage. They did not use any specific tools or rating scales for triaging patients. National guidance recommends that services consider using a rating scale during triage that classifies the risk of self-harm into five categories to help assess the level of supervision of the patient and other actions to mitigate risks. However, staff recorded risks as part of the general assessment. For example, the initial assessment in one record stated that the patient was experiencing suicidal ideation. Specialist mental health services completed more thorough risk assessments and included these on the patient record.

Police may detain members 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 which are formally designated Health places of safety while potential mental health needs were assessed under the mental health act. In theory the mental health room in ED could be used as place of safety. The local protocol states that emergency departments cannot refuse to such patients’ access unless formal escalation action has been taken. However, the trust told us subsequently that no patient was bought into ED or into the hospitals mental health room if they had no health needs.
Patients needing medical treatment and were in police custody were treated within the main ED as assessment of their condition dictated. The mental health room was used only if it was believed that this was the most appropriate place for the patient. The police normally stayed with the patient until a doctor had examined them to see what treatment was needed. Once the patient had received any necessary medical treatment, the police took the patient to the designated health-based place of safety.

The trust did not analyse records of occasions on which the police brought patients to the ED, although this information could be extracted from the ED patient registration system. The system did not record ‘to provide a place of safety under the Mental Health Act 1983 (MHA)’.

Staff in ED were not sufficiently well-trained to identify and mitigate risks to adults with mental health issues in the interim period before a specialist mental health professional arrived. For example, we reviewed the records of one patient admitted following an overdose. Although the initial assessment of the patient had identified they were experiencing suicidal ideation, staff did not enquire whether the patient had any medicines with them, or place the patient under enhanced observation, such as from a registered mental health nurse. The patient took a further overdose at the emergency department. However, we did not have evidence that this was a systemic issue.

In addition to receiving help from the child and adolescent mental health services, staff told us they also signposted young people with mental health concerns to an online mental health and wellbeing service offering self-help programmes, creative outlets and where they could chat with a registered mental health nurse, as well as to other local and national agencies.

At the last inspection patients in four cubicles could not access call bells. All patients seen on this inspection had call bells within reach.

The trust’s scored “about the same” as other trusts for all questions in the Emergency Department Survey 2016 in relation to the safe domain.

<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 emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<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 01/09/2016 - 30/09/2016)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard during the 12 month period from November 2016 to October 2017, with times of more
than 80 minutes on average each month over the year.

(Area chart showing ambulance turnaround times from November 2016 to November 2017)

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

Ambulance turnaround time did not meet the national indicator for handover. On the last inspection the trust did not meet ambulance turnaround standards 64% of the time. However, records from December 2016 to November 2017 showed a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at King George Hospital.

(Bar chart showing ambulance turnaround times from December 2016 to November 2017)

(Source: National Ambulance Information Group)

Staff reported ambulance turnarounds over 30 minutes as incidents.

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 October 2016 to May 2017 the trust as a whole reported 39 “black breaches” with no trend over the period. There were fewer black breaches at King George hospital. In the past three months to February 2018 no ambulance had waited over 2 hours. In the week of our inspection 21 February 2018 there was one black breach at this site compared to four breaches in the trust’s other emergency department.

Nurse staffing
The Department had longstanding challenges in recruiting permanent ED staff.

At the last inspection there was a shortage of paediatric nurses, and although the position had improved, this remained on the risk register. Nurse recruitment was in progress and more appointments were made during our inspection.

There were three nursing shifts a day, early, late and night. Staffing was planned according to the known pattern of attendances, but could be flexed according to which area was busiest. The establishment was 13 trained nurses, two in the paediatric ED and 11 in adult ED for the morning shift. There were 14 nurses in the afternoon, and on each shift there were also two accident department assistants (ADAs) and one healthcare assistant. Overnight (8am to 8pm) there were 11 nurses and an ADA. In addition two nurses worked twilight short shifts (18.00 – 02.00) to support staff at a known busy period of the day. On the first day of our inspection there were two nurses short in the day and two at night, due to sickness. Several staff, some senior, did not feel the establishment figures were enough to care for the numbers of patients currently presenting to the department. From the incidents recorded and rotas it was clear that the number of staff had recently fallen below establishment on a number of occasions. The impact on patients was longer waiting times for assessment and treatment and less personal attention as each nurse had to take responsibility for more patients.

The trust reported their registered nursing staff numbers as below from 30 September 2016 to 30 September 2017. Information provided by the trust was not broken down to individual hospital sites.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>223.30</td>
<td>158.29</td>
<td>71%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

At the last inspection nurse vacancy levels were 50%. The trust had a rolling recruitment programme and interviews were taking place during our inspection. The vacancy rate had reduced to 30%. We noted that most vacancies were filled with bank staff.

From October 2016 to September 2017, the trust reported a turnover rate of 1.3% in urgent and emergency care within nursing staff. This rate met the trust’s standard of 13%. The overall turnover rate for nursing staff across all core services was 1.4%. Turnover at this site was 0.7%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Exit interviews were carried out when staff left. Of the 26 leavers between August 2017 and January 2018 nine were medical staff and 13 were nurses. Six doctors were on fixed term contracts. Eight staff were relocating, five cited work life balance and others had dependents. 10 of the nurses were band 5. We learned that action was being taken to give more support to band 5 staff to encourage retention.

From October 2016 to September 2017, the King Georges hospital reported a sickness rate of 4% in urgent and emergency care for nursing staff. This did not meet the trust’s target of 2.8%.

From October 2016 to September 2017, the trust reported that 49% of all vacant shifts within urgent and emergency care were covered by bank and agency staff. The trust did not provide breakdowns by site.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
The matron told us most agency nurses who worked in ED at King George Hospital were regular agency nurses. On the first day of this inspection the only agency nurse had previously been a member of staff. However, we were told that two agency nurses employed the previous night to cover late notice sickness, had not met trust requirements. The matron told us the agency had been notified and those staff would not be employed in the department again. Poorly performing agency staff put a burden on other staff. In this case agency staff had carried out routine observations on their patients which had been reported as an incident, even though no harm had resulted.

We spoke with a bank nurse and an agency nurse who both found the department welcoming and flexible.

RCN guidance recommends one registered nurse to four cubicles in major or minor trauma. This was in line with the establishment figure for the trust, but was not achieved during our inspection. In majors there should be one nurse to four patients, but on inspection there was one nurse to six patients because of sickness and carer leave. Staff said they mostly got breaks and covered for each other to allow this.

In the children’s ED there was always a nurse with Paediatric Intermediate Life Support training. In addition there would always be a paediatrician with APLS as this was requirement for working in ED at the trust.

**Medical staffing**

Medical staff in emergency care rotated between the two hospitals. Ward paediatricians supported the paediatric ED.

The Department had longstanding challenges in recruiting permanent ED medical staff. At the last inspection there were concerns about insufficient senior medical support, insufficient permanent consultants. At this inspection there had been some increase in the number of permanent consultants employed by the trust, and consultants told us there was 24 hour cover five days a week. For children a paediatric consultant was on call at night. Three consultants were available on site during the day on Monday to Friday. If there was no consultant at King George hospital at any time, for example, because of sickness, an on-call consultant based at Queen’s hospital could be contacted.

Trainee doctors rotated to the trust’s other emergency department at Queen’s hospital every four to six weeks. They reported enjoying work at King George’s ED because the compact design of the unit facilitated good team working and support.

The trust reported their registered medical staff numbers as below from 30 September 2016 to 30 September 2017. Information provided by the trust was not broken down to individual hospital site.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>79.88</td>
<td>47.50</td>
<td>59%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

At the last inspection there had been a 40.6% vacancy rate overall amongst medical staff. On this inspection the vacancy rate had reduced to 31%.
At the last inspection we found high rates of consultant vacancies, 46%. At this inspection, the 61% of consultants were permanent staff which was an improvement. Locums covered the shortfall in substantive doctor numbers. (Locum medical staff are fully qualified doctors but they do not always have the specialist skills required for treating patients in emergency situations). We were told most locums were long term.

On this inspection we found the trust continued to rate the level of permanent medical staffing high risk. On the two days of the inspection in February 2018 rotas showed the department was fully staffed with good skill mix through the 24 hours. Between Tuesday and Thursday additional consultants are on site for governance and teaching in the morning and clinical work in the afternoon. There was a resident night consultant on both days. Additional night shifts were covered to help manage the high level of demand.

At the last inspection we found a high number of vacancies for middle grade doctors. There continued to be gaps at this grade, mainly covered by locums. However, recognising that some staff preferred locum work the trust offered training opportunities, and long term locums could be allocated an educational supervisor with opportunities for job rotation through emergency medicine, paediatric emergency medicine, acute medicine and anaesthetics. This had increased recruitment and retention.

ED had an almost full establishment of trainee doctors, with an extra allocation of a junior doctor in their fourth year of speciality training this year and an extra trainee in their second post graduate year, since August 2017. There were only two trainee posts not currently filled. The department had worked hard to improve the training and support given to trainees.

The trust was seeking ways improve recruitment and make medical posts more attractive to new recruits by offering more flexible hours and opportunities to develop skills in other areas of medicine alongside ED work. Managers had improved the in-house bank rates to compete better with agencies. However challenges remained; there is a national shortage of ED doctors; the workload at the trust was intense and there was a historical negative perception of the Trust's emergency department which the trust was trying to overcome.

Managers had run two recruitment workshops for consultants and junior doctors during the past three months. Consideration was being given to incentives such as free accommodation for recruits from more than 150 miles away and child care. This had attracted 25 doctors. The trust were advertising for doctors in South Africa and India.

There were no clinical fellows although HR confirmed that two clinical fellows were due to start in April 2018.

From October 2016 to September 2017, the trust reported a turnover rate of 4.4% in urgent and emergency care within medical staff. This was higher than the trust overall turnover rate for medical staff of 1.2%. This rate met the trust’s standard of 13%. The trust did not break down information on staff turnover for medical staff specific to sites because they worked cross site. *(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

From October 2016 to September 2017, the trust reported a sickness rate of 2% in urgent and emergency care for medical staff. This met the trust’s target of 2.8%. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

The trust reported that there were some bank or locum doctors on 84% of vacant shifts within urgent and emergency care between October 2016 and September 2017. *(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*
Staff told us locums used at the hospital were regular locums and were supervised by consultant on duty. A bank locum we spoke with said they had two weeks induction shadowing other doctors and felt well-supported by medical colleagues.

In August 2017, 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 average for England.

**Staffing skill mix for the 44 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>18%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>14%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>50%</td>
<td>23%</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)

Administrative staff worked rotated between the trust’s emergency departments. Three reception staff divided their shifts between the walk-in reception desk, the ambulance reception and the paediatric reception so all had skills in all areas. Staff used a telephone application (app) to advertise vacant shifts and this had improved shift fill.

Administrative staff worked in the ambulance reception until 2am, after which time the reduction in the number of patients arriving by ambulance or their own means, enabled administrative staff at the reception desk to take details of all patient admissions until 8am.

Part of the reception role was to check the patient details against central NHS patient information records, and update personal information on the trust patient information system, to ensure all information onto the ED’s patient record system was up to date.

**Records**

Records were a combination of computer records, on more than one computer system, and paper treatment records. Some of the IT systems did not communicate with each other automatically so, for example, the electronic system for reporting national early warning scores could not feed into the ED patient record system. However, clinicians could view discharge summaries from previous admissions on the hospital’s main patient record system.
The ED patient record system showed the patient’s name and the time of each event during the patient’s journey through the department. For example, the times of arrival, triage, medical tests and discharge time. The paper treatment record of the patients’ care included notes by nurses and doctors and details of any blood test results, NEWS scores, electro-cardiogram results and a record of medicines that staff administered. Imaging results were on a computer system.

Some clinicians expressed frustration with the combined paper and electronic system because not all records were accessible in the same place which could delay treatment.

At the last inspection we found records were not securely stored and were left in places where they were accessible to the public. At this inspection, records were securely stored in trolleys near the nurses’ station.

We saw that missing medical records on re-attendance was a concern, and on the risk register. An example we observed was of a patient who had been discharged from ED at midday the previous day, but recalled that evening following results of diagnostic tests. The patient told us it took six hours to find their paper notes before treatment could be started.

There was a monthly audit of nursing documentation. Results for January 2018 indicated 100% scores for contact details of patients and next of kin, but only 87% for completion of all assessments. This indicated there was a less good patient experience when the department was under pressure from high numbers of patients attending ED.

We looked at 21 sets of patient records and we found NEWS charts were well completed. Key patient information was on every sheet.

For mental health patients, the specialist mental health professional who assessed the patient added a summary of their assessment to the patient record.

The psychiatric liaison team were able to access records held both by the acute trust and the mental health trust. This meant that staff could access information about a patient’s history and previous admissions promptly to optimise treatment.

**Medicines**

There was no pharmacist specifically for ED. Drugs were ordered twice weekly for all units in ED. Matron told us the department had needed to order higher quantities of medicines and consumables since January 2018 to ensure there were sufficient stocks for the increased number of patients. We saw that staff took responsibility for noting low stock and recording it on an order list in the nurses’ station. We saw adequate stocks of drugs, antidotes and IV fluid during our inspection.

Medicines (included controlled drugs) were stored securely in locked rooms and were accessible only to authorised staff. The trust had implemented an automated system to manage stock levels and help re-order medicines when supplies were low. An audit trail of staff accessing the cabinet was available. We reviewed controlled drugs records and saw that daily checks were made to reconcile stock levels with records of usage.

Maximum and minimum temperatures of fridges used to store medicine were checked and recorded each day to ensure medicines were stored within the safe temperature range set by pharmaceutical manufactures. Fridges were locked. At the last inspection there had been temporary problems with the air conditioning which meant some fridge temperatures were too high. We found no temperature control problems on this inspection. We saw evidence of daily checking of the temperature of rooms.
We asked a pharmacist about a December 2017 audit on safe and secure management of medication for KGH ED which showed 50 medicine administration errors, 25 prescribing errors and 67 dispensing errors. The number of dispensing errors was higher than expected and we were told the department would follow the trust medication errors policy, completing an incident form, and informing the Senior Pharmacist and returning the incorrect medication. 

The chief pharmacist had directed that medical gases could only be prescribed by a registered medical practitioner. Following this, pharmacy had provided training on prescribing and correct administration of medical oxygen to patients.

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.

**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 December 2016 to November 2017, the trust reported no incidents classified as never events for urgent and emergency care.  

*(Source: NHS Improvement - STEIS)*

In accordance with the Serious Incident Framework 2015, the trust as a whole reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2016 to November 2017. At King George hospital there were four serious incidents. Serious incidents were subject to root cause analyses which were thorough. All medical trainees said learning from serious incidents was widely disseminated. There were no outstanding serious incident investigations

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>King George Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>0</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>1</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm</td>
<td>1</td>
</tr>
<tr>
<td>Adverse media coverage or public concern about the organisation or the wider NHS</td>
<td>0</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4</td>
</tr>
</tbody>
</table>

*(Source: NHS Improvement - STEIS)*

The trust’s incident reporting figures were above the national average and the trust held bi-yearly incident reporting weeks to encourage reporting amongst all staffing groups. Staff told us incident reporting was blame-free. Senior staff considered the reporting threshold was low, which
encouraged reporting. The department reported on average 100 incidents a month. The proportion of low or no harm incidents was similar in each month. Staff said there was increase in incidents being reported for bed capacity during recent months. The majority of incidents of all kinds were reported in the adult emergency department, although not always consistently classified by cause which hindered analysis.

Top themes of incidents for children were medication, clinical care and appointment, transfer and discharge. The top themes for adults were tissue viability (identifying community-acquired pressure ulcers), clinical care, documentation, communication and medication. Monthly ED quality and safety (clinical governance) meetings reviewed incidents.

At the last inspection we received mixed feedback from staff regarding learning from incidents. This time we saw that staff were thanked for reporting incidents, and received feedback. Learning points from incidents were shared through a range of methods including directly through personal email, in newsletters, on the intranet and at staff meetings. Staff in the paediatric ED said learning from incidents had improved considerably in the last two years and staff received good feedback and opportunities for learning. Staff of all levels came together after an incident involving patient care to discuss what went wrong and what can be learned. For example, staff mentioned a reflective session after an emergency delivery of a baby in the car park. Nurses said the daily team brief was useful in communicating learning.

One area of weakness was consistent recording of incidents of restraint. We noted that such incidents were not consistently reported on the electronic incident record. We did not see guidance for staff on reporting incidents relating to patients with mental health issues. Staff told us on inspection that the department did not keep specific records on restraint of violent and aggressive patients, or the use of rapid tranquilisation. This meant staff could not monitor the use of restraint to ensure it was used proportionately and safely. We reviewed the record of one patient who had taken an overdose whilst at the emergency department. There was no indication on the patient’s record that this had been reported as an incident. However, the trust told us after the inspection that they were able to extract restraint data, and told us there were 23 incidents of Aggression and Self Harm with the following breakdown between 1 January 2017 and 31 March 2018.

The quality and safety section of the trust intranet had information on Duty of Candour, learning from incidents and learning from safeguarding cases. These were readily accessible to all staff.

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. When an incident was graded as moderate or above a duty of candour ‘flag’ was generated in the incident reporting system. This prompted the need to contact the patient and family within 48 hours to apologise when things went wrong, following this up with a letter within 10 days. The trust’s Duty of Candour standard operating procedure guided clinicians on when the Dock regulation applied, the timescales, the staff member(s) responsible for the required actions. There were model letters to formally communicate with the patient and relatives as appropriate.

The ED had regular violent incidents (15 incidents were serious enough to record on the reporting system in the three months to mid-February 2018). Two security staff were always in the ED area, one on patrol and one monitoring the closed-circuit television surveillance of the area (CCTV). The trust had a zero tolerance policy to bullying, abuse and violence. Staff followed a staged warning
system to caution patients or the public who were violent or abusive, which could ultimately lead to withholding treatment.

The security services were provided to the trust under contract. Their training included conflict resolution, manual handling, health and safety and report writing and autism awareness. Security staff did not have specific training on mental health and mental capacity. However, despite the lack of training, the security staff we spoke with demonstrated good awareness of mental health issues developed through experience.

**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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new (hospital acquired) pressure ulcers, two falls with harm and no new catheter urinary tract infections from November 2016 to November 2017 within urgent and emergency care. The falls occurred in February 2017 and March 2017.

A standard checklist was used with relevant patients to assess the risk of falls.

---

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barking, Havering and Redbridge University Hospitals NHS Trust**

- **Total pressure ulcers (0)**
- **Total falls (2)**
- **Total CUTIs (0)**

---

![Graph showing prevalence rate of pressure ulcers, falls, and CUTIs at Barking, Havering and Redbridge University Hospitals NHS Trust](image-url)
**Major incident awareness and training**
A major incident plan was available on the intranet, and associated action cards were accessible to relevant staff. This plan provided clinical guidance and support to staff on treating patients in the event of different kinds of emergency incident.

The head of emergency planning coordinated planning across both King George and Queens Hospital sites. A rolling major incident training programme was designed to reach as many staff as possible.

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority. All staff were aware of this.

**Is the service effective?**

**Evidence-based care and treatment**
The Trust’s evidence based practice group (EBPG) was responsible for ensuring that new (or new to the trust) procedures and clinical processes were evidence-based and in line with known best practice and current guidance.

The policies, care and treatment pathways, and clinical protocols we reviewed were based upon recognised guidance, including that of the National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). This was an improvement because at the last inspection we found a number of clinical guidelines on the trust intranet were out of date. However, there was a lack of policy and guidance on mental health, for example on the NICE guidelines relating to self-harm.

Staff, including locums, told us guidelines were easy to access. We reviewed a selection of proformas for procedural sedation and for different types of heart attack or stroke which were in line with national guidance. We also checked some children’s guidelines for child and adolescent mental health (CAHMS) referral and anaphylaxis. These were up to date and clear.

We observed clinical practice by both doctors and nurses which was within published guidelines.

We saw that the trust had carried out a detailed review and update of the trust’s e-learning packages following the publication of the NICE guidance on sepsis (July 2016).

The department undertook regular audits, these included national audits requested by the Royal College of Emergency Medicine (RCEM); others were based on NICE guidance such as pain management. A medical research group audited clinical practice in the ED to identify areas for improvement in patient care.

Nineteen audits had been completed during the last audit year (1 April 2016-31 March 2017) for example, Compliance with the Safeguarding Children Trigger Checklist in ED.

On this inspection we found a clinical audit programme in place for 2017-18, but work on neither of two national audits this site was doing, management of pain in children and procedural sedation in had not started. Only one of four local audits, measurement of current practice in emergency treatment of suspected anaphylaxis had started. The lack of progress had been noted in a
governance meeting and clinicians had been asked to prioritise completion. Paediatric staff told us about an audit of discharge of children from ED and comparing management of pain in children to RCEM standards. There was an ongoing audit on anaphylaxis in children and a survey of children treated in the resuscitation area.

There were also monthly 'quality of care' audits. In January 2018 all patients in the audit sample had wristbands, seven out of 10 had a falls risk assessment and seven out of 10 had a risk assessment within 12 hours.

There were arrangements for older and frail people who might be vulnerable to be referred for a more holistic assessment of their needs. The team liaised with social services, family and local community services. Team members visited ED regularly to support patients aged over 75.

### Nutrition and hydration

We saw patients being offered food and drink where appropriate if they were in the department at mealtimes. The Malnutrition Universal Screening Tool (MUST) was used to assess patients’ risk of being under nourished.

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 01/09/2016 - 30/09/2016)

### Pain relief

The Faculty of Pain Medicine standards say that acute pain must have an individualised pain plan appropriate to their clinical condition that is effective, safe and flexible, and that all in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs. We saw evidence of staff carrying out comfort rounds to assess people’s comfort, including pain and recording this in patient notes in line with the Faculty recommendations.

There was a display board in reception inviting people to tell staff if they were in pain. Staff aimed to give pain relief within 15 minutes and patients we spoke with told us they were offered pain relief soon after they came into the department, and were satisfied with the pain control. Patient records we looked at contained completed pain charts. Staff told us a pain score audit was in progress.

Children’s pain scores were recorded on a standard child friendly chart using a series facial expressions, scored from one to ten, depending on the severity of pain.

Staff in ED had access to advice from a consultant led pain management service with a team of nurse pain specialists.

In the CQC Emergency Department Survey 2016, 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. However, these results related to September 2016 which was fifteen months before our inspection in February 2018.

<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</td>
<td>4.2</td>
<td>Worse than other</td>
</tr>
</tbody>
</table>
Patient outcomes

At the last inspection we had required the trust to ensure all patients attending the ED were seen by a clinician in a timely manner. A quality of care board was on display in reception which showed the time to initial assessment, which showed an improving trend. 82% of patients were seen, treated and discharged within four hours in January 2018. The information board also showed the number of falls, compliance with the screening and treatment for sepsis (and compliments and complaints.

The Department carried out monthly local audits on sepsis and infection control to assess whether patients were receiving appropriate and safe treatment.

Records show that children and young people with mental health issues were triaged quickly, a 15 year old was triaged in four minutes and an 18 year old was triaged in nine minutes. Treatment provided appeared appropriate.

The hospital took part in several of the RCEM audits so that it could benchmark its practice and performance against best practice and other urgent and emergency departments. As the audits in 2016/7 were different from the 2013/4 audits reviewed at the previous inspection, no direct comparison was possible. The hospital did not take part in the RCEM audits on vital signs in children 2015/16, procedural sedation in adults 2015/16 or Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16. The trust subsequently told us that KGH ED had been part of RCEM national audits since the cycle of 2016-17.

In the 2016/17 Moderate and Acute Severe Asthma report, the King George Hospital did not meet any of the audit standards of 100%, but 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. Hospital Score: 96%; UK: 77%.
- Standard 5a: If not given before arrival to the ED, steroids given within one hour of arrival (where an acute severe attack has taken place). Hospital Score: 67%; UK: 19%.
- Standard 5b: If not given before arrival to the ED, steroids given within four hours (when a moderate attack has taken place). Hospital Score: 91%; UK: 28%.

The hospital’s results for the remaining four metrics were all between the upper and lower UK quartiles which meant they were broadly compliant with the audit.

In the 2016/17 Consultant sign-off audit King George hospital was in the lower UK quartile for two standards:

- Proportion of atraumatic chest pain patients aged 30 years and over seen by a consultant. Hospital score 2%, national median 11%.
- Proportion of patients making an unscheduled return to the ED with the same condition within 72 hours of discharge (seen by a consultant). Hospital Score 3%, national median
The hospital’s results for the remaining two standards were between the upper and lower UK quartiles.

In the 2016/17 severe sepsis and septic shock audit, King George Hospital was in the upper 25% of trusts for one standard:

- Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital Score 87%, National aggregate 65%.

The hospital was in the lower UK quartile for three standards:

- Antibiotics administered: Within one hour of arrival. Hospital Score 23%, National aggregate 44%.
- Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival. Hospital Score 22%, National aggregate 43%.
- Serum lactate measured: Within one hour of arrival. Hospital Score 28%, National aggregate 60%.

The hospital’s results for the remaining four metrics were all between the upper and lower UK quartiles.

However, the department’s local audit in 2017 following significant focus on sepsis treatment and management to improve patient care, showed much improved overall performance.

- The trust achieved 90% or greater in serum lactate measured.
- Blood cultures were achieved within 1 hr in 84% of cases audited.
- Urine output was measured within four hours in 14% of cases.
- Sepsis screening within an hour was 100% up to December 2017, although results had shown a dip in January 2018 which staff attributed to the higher volume of patients seen that month.

NHS England had recently commended the trust for being one of the trusts which had seen the greatest improvements in performance in assessing and treating sepsis within its emergency departments.

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and worse than the England average over the whole period. This trust’s performance in this metric saw a slight improvement over this period towards the average for England:
Competent staff

There was a focus on teaching, learning, and professional development in the department in both the medical and nursing teams. Staff told us the education budget had been cut across the trust which had affected attendance at external training but to compensate for this, more in-house training had been developed. For example, ED had its own trainers for adult life support. A monthly programme of intermediate life support training had started in January 2018 and the trauma network was funding two nurses to do Advanced Life Support training (ALS). Five children’s nurses had been funded for places on the European paediatric advanced life support course.

Staff told us there was monthly practical training in emergency department skills and routines.

New junior doctors attended a full induction day that included safeguarding, ambulatory care package, complaints clinical governance, sepsis, pharmacy, life support and a tour of the department. There were set times each week for junior doctor training. Consultants prioritised the education of trainees, training sessions were mandated and not cancelled, and trainees reported that training was of a good quality. Trainees said they were assigned to a senior doctor for additional support, whom they met face to face every three months. They completed forms reporting on their experience of working in ED and their training, to monitor the training experience. Junior doctors reported good in house teaching including 1:1 support, which included training on diabetes, arterial gases and sepsis.

New nurses and support staff were required to complete competencies such as patient assessment and caring for adults requiring resuscitation before being allowed to work in specific areas of the emergency department.

Agency nurses said they had a tour of the department and followed an induction checklist which was recorded, before starting their shift.

Practice development nurses (PDN) supported nurse education within the emergency department by auditing nurse practice and identifying training needs. This nurse had set up an innovative rotation programme for newly qualified paediatric nurses. They spent four months in paediatric ED, four months in the neonatal unit and four months on the children’s ward. The department had also set up a new intern programme to provide pastoral support, coaching and mentoring for newly qualified nurses to prevent them becoming demotivated and ultimately leaving. This had been a success and two additional nurses had been recruited to expand the scheme.
Many ED nurses said they had undertaken conflict resolution training which they said was very helpful. Paediatric nurses said this helped them deal with parents; anxieties and also how to respond to different cultures where misunderstandings could arise over treatment normally provided in ED. Staff told us they had access to a range of online training.

One of the paediatricians gave some formal training to staff in the paediatric ED on topics such as diabetic emergencies and interpretation of blood gas test results, and we saw records of this.

Nurses attended structured training days four times a year. The training days including learning from incidents and complaints, and training on governance to discuss audit data and what could be learned from it.

The trust was unable to provide appraisals information broken down to CQC core service or individual hospital site because this information was managed across the trust. Information provided below covers the trust’s ‘Acute Medicine Division’ of which urgent and emergency care was part.

From April 2017 to October 2017, 84% of staff at the trust had received an appraisal compared to a trust standard of 85%. A breakdown of appraisal rates by staff group is below:

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Number of individuals trained - Apr 17 to Oct 17</th>
<th>Sum of Number of individuals required - Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Trust standard</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scientific and Technical</td>
<td>1</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing</td>
<td>329</td>
<td>367</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>154</td>
<td>201</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>87</td>
<td>98</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>571</td>
<td>671</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

On inspection we learned that the division had achieved the appraisal target of 85%. The process was known as the positive performance review process and assessed all staff against the trust’s values. Nurses told us the process encouraged them to learn from the previous six months and identify what had worked well and what they could improve.

We were told that locums had a paper based feedback/appraisal system but that managers were in the process of developing an online system that would allow for centralised recording and reporting.

**Multidisciplinary working**

We observed good multi-disciplinary team working and positive interactions across all staff levels within the department. Staff we spoke with told us there was a good working relationship between all levels of staff.

We observed good patient handovers between staff within the emergency department and between hospital and ambulance staff.
A consultant told us that emergency medicine services were well integrated with the rest of the hospital and that staff across the hospital acknowledged that all wards had a role to play in freeing up beds for ED patients needing admission, and so improve the flow through the emergency department. Areas that ED liaised with most closely to improve patient flow were the medical assessment unit, children’s services, imaging and older person’s ambulatory care and the frail and older person’s advice and liaison service (FOPAL). FOPAL was an admission avoidance team who were alerted by ED to all patients aged 75 and above in the department so they could support discharge planning for these patients to prevent hospital admission as far as possible.

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 was based within the emergency department. The Psychiatric Liaison Team operated within the ED 24/7 and had access to the Acute Crisis Assessment Team (ACAT), Home Treatment Team, with 24/7 cover for AMP when needed. ACAT was also able to admit patients to mental health wards at the nearby hospital without the need for further assessment. When patients were intoxicated, the psychiatric liaison service assessed whether it was possible to carry out a mental health assessment. If it was not possible, staff attended the patient again when they were less intoxicated. The service carried out psychosocial assessments in accordance with national guidelines.

A nurse from the alcohol liaison service was available to support the service up to four days each week, which staff considered adequate cover. When the specialist nurse was not available, staff arranged appointments for patients.

The paediatric service could refer patients to a specialist child and adolescent mental health service (CAMHS) between 9.00am and 5.00pm from Monday to Friday. Outside these hours, staff could contact an on-call duty psychiatrist.

Staff working for the psychiatric liaison team said the two services enjoyed a good working relationship. Staff at the psychiatric liaison service said that ED staff were approachable and supportive. The acute medical division nurse and associate specialty manager attended meetings with the mental health trust to review and look at cases, attendance numbers and re-attenders and to formulate care plans for individuals.

Staff said there was generally effective collaboration with the UCC.

**Seven-day services**

The emergency department was open 24 hours a day throughout the year. This was for both adults and children.

Diagnostic imaging at this hospital was available 24/7. If imaging was not urgently needed for diagnosis, patients were given an appointment early next day and returned to ED for imaging. We spoke with a patient who had returned at 9am for a CT scan after treatment the previous night, and they were satisfied with the process.

Consultants told us there was 24/7 consultant cover at least five days a week, with one resident consultant at night after 11pm. However, the trust said they now aimed to provide consultant cover seven days a week. There were always on call consultants for adults and children.

A dedicated ED paediatric consultant was available 6 days a week for eight or nine hours a day. Night paediatric consultant cover was from the paediatric ward. We were told the level of paediatric medical cover at night was to be reduced from 2 registrars and 2 SHOs to one at each
level from April 2018, but there was always on call cover if paediatricians needed advice from a paediatric consultant.

Clinical pharmacy services were available seven days a week with shorter hours on Saturdays 9am and 3pm and on Sundays 9am and 12pm. An on-call pharmacy service was available out of hours. Staff had access to emergency stocks of medicines at all times.

Nursing staff informed us they were able to access blood test results sent to the laboratory within one to one and a half hours on all days. However, a new system was to be introduced where new equipment in the emergency department itself could be used to test blood and urine, and this would provide diagnosis more quickly. All staff were being trained on the new equipment. Quicker results, within 12 minutes would enable clinicians diagnose and treat patients more quickly. This would help speed up patient flow through the department.

**Health Promotion**

The waiting room had a screen showing health promotion information including showing strengthening exercises, information on reducing sugar intake and smoking cessation. There were also health posters displayed on the walls, as well as information for patients about how to raise a concern.

Within ED there were leaflets for patients and carers about care after injury or illness which staff could give patients and carers. There was information in the paediatric emergency department for parents and carers about common childhood illnesses.

There was also information for patients about sepsis and what signs to look out for.

In the paediatric service staff were developing a screening group for child obesity involving the whole family.

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

Staff we spoke with had a good understanding of the need for valid, informed consent for health interventions. The nature of emergency medicine dictated that there were rare occasions when written consent was required. Staff were therefore focused upon patients giving them verbal or implied consent. We observed verbal consent taking an appropriate recording.

The trust policy on consent to examination and treatment set out the process for obtaining informed consent from, or on behalf of, patients, and how to proceed when a patient could not consent. At the last inspection we had found little evidence of consent recording. This time all the records we reviewed showed evidence of consent.

The trust provided online training on the mental capacity act and deprivation of liberty safeguards and 89% of staff had this training. We reviewed the content of this training which had had good coverage of capacity issues. The trust had a policy on the Mental Capacity Act 2005 but there was no policy on the Mental Health Act 1983 and 2007. Senior staff told us the mental health component of the training for nurses was under review.

A nurse from psychiatric liaison service attended teaching days for staff within the emergency department where they discussed managing patients who presented with mental health issues.

The trust subsequently told us that there had been mental health training on KIT days since January 2017. This had reached almost all permanent nursing staff by May 2018.
Information about training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) was for the trust’s ‘Acute Medicine’ division, which includes the emergency department. The trust set a standard of 90% for completion of MCA/DOLS training. A breakdown of compliance for safeguarding courses from April to October 2017 for medical and nursing staff is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Standard (%)</th>
<th>Standard met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>24</td>
<td>108</td>
<td>22%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>257</td>
<td>365</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust failed to meet the standard for both nursing and medical staff, with 22% medical staff completing MCA/DOLS training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Although at that date the trust had failed to meet the standard for both nursing and medical staff, we found on inspection that 89% of staff had completed training on the mental capacity act. Some staff showed understanding of the principles of the mental capacity act in relation to patients who were not able to make their own decisions, but not all staff recalled having training and showed less understanding of the principles.

The mental health team or doctors carried out mental capacity assessments. Some clinicians carried out brief mental capacity assessments known as ‘mini-mental state’ assessments for patients who may have dementia. We reviewed the record of one patient which did not include an assessment of the patient’s mental capacity to agree to admission or treatment at the emergency department.

The trust policies for safeguarding adults and for safeguarding children detailed how to identify a patient who did not have the capacity to give consent, including applying Gillick competency checks for young people. This is when it is appropriate for consent to be obtained from a child under the age of 16 without the knowledge or authority of the parent.

If a patient required an assessment for admission under the Mental Health Act between 9am and 5pm, the doctor from the psychiatric liaison team completed the first medical recommendation and contacted an approved mental health professional. Outside these hours, the service contacted a duty psychiatrist to complete the first assessment. This meant the process could take longer outside office hours.
Is the service caring?

Compassionate care

During our inspection we saw and heard many examples of staff treating patients with compassion, dignity and respect, despite the busy environment. We saw kind and caring attention given to a confused and distressed patient and kind and supportive care given to children.

We observed staff introducing themselves by name and explaining their roles to patients. Patients also confirmed staff introduced themselves.

Three patients who had used the hospital before reported that the care and compassion of staff had improved.

We spoke with 17 patients and five family members. The experiences of all but one were positive. Patients described staff as “amazing” and “doing all they can to help”.

One patient admitted with mental health issues told us that staff were kind. They said that staff treated them in a caring manner and that this was different to their experience of other emergency departments in the local area.

The percentage of patients recommending the trust for urgent and emergency care under the Friends and Family Test was generally worse than the England average from November 2016 to October 2017, however performance improved between June and August 2017:

(Source: NHS England Friends and Family Test)

November 2017 figures averaged 90% positive. The response rates were high, a 53% response rate for adults and a 48% response rate for children. The children’s ED at King George had positive results, especially relating to staff and children being treated with dignity there was an upward trend since November 2017.

Almost all patients we spoke with said they were treated with dignity and respect.

Emotional support
Staff we spoke with understood their role in providing emotional support to patients and their families. We observed staff providing sympathetic and professional support to a distressed parent.

The ED staff had a protocol on how to support relatives who experienced bereavement. We witnessed how staff dealt with recently bereaved relatives in a caring and compassionate way. We observed sensitive behaviour towards a family when a patient was approaching the end of their life. A multi faith chaplain was available to patients for emotional support if required.

Staff were supported after a traumatic event with same day group reflections.

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

Patients and relatives told us they felt well informed about the processes in the department. Information in the main waiting area explained each pathway, majors, minors, UCC and paediatrics and the queueing systems. Inside ED there were explanations of the processes, and information about the staff uniforms so patients and their relatives could identify staff job roles. Staff also introduced themselves and explained their roles.

Patients told us they had regular updates on their care and treatment. One relative commented that “staff kept me informed and made sure I understood.” Another patient told us, “staff have explained everything very clearly.”

Parents and carers accompanying children in the paediatric ED were pleased with the treatment of their children. They said the nurses and doctors were professional, supportive and knowledgeable.

Leaflets were available in the department for staff to give to patients being discharged from the ED on common conditions such as care after back injuries to back up information that staff had given.

The trust scored about the same as other trusts in the 2016 A&E survey for giving patients the right amount of information about their condition or treatment and for being involved as much as they wanted to be in decisions about their care and treatment. The results of the survey showed the trust scored about the same as other trusts in half the questions, but had scored less well on questions relevant to caring. A summary of all scores under the caring domain is below. We saw evidence that the results had been discussed with staff so they could consider their behaviours.

<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>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</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>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>Q25. 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>Q26. 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>Q27. 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>Q28. 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>Q29. 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>Q30. 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>Q31. 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>Q32. 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>Q33. 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>Q34. Overall... (please circle a number)</td>
<td>7.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Is the service responsive?**

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

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. These patients were taken by ambulance directly to the other hospital in the trust, Queen’s hospital, which had a wider range of specialisms. However the service did treat walk-in children in their children’s ED.
If walk-in patients attended ED requiring support with such conditions which was unavailable at KGH. The policy was to assess and stabilise them and then transfer them to Queen’s hospital. When patients arrived at ED there was clear signage which directed patients to the reception area. Patient details (such as name, date of birth and address) and a brief reason for attending the centre were recorded on the computer system by one of the reception team. A receptionist would also complete a brief set of safety questions to determine ‘red flags’ which might mean the patient needed to be seen by a clinician immediately. At the last inspection we heard that waiting times were long and at the lowest point (March 2016) 25% of patients waited over four hours. Waiting times were still longer than four hours for about 16% of patients. However, patients we spoke with were tolerant of this because they had information about the maximum waiting times. Patients we spoke with were not deterred by the wait. One person told us ‘if you come to A&E you expect to have to wait for results’. Another had been waiting 2.5 hours for a surgeon follow up, but was likewise not concerned about the wait. Another patient complained of waiting 2.5 hours, but in that time had been assessed and had diagnostic tests. The waiting area had over 80 seats, a television and an electronic display screen showing information about the journey through the emergency department including queuing priorities and current waiting times, interpreters and health information. There was a coffee machine and vending machines for cold drinks and snacks.

People being assessed or treated ED at mealtimes had meals provided. There was a display board inviting people to tell staff if they were in pain, if they would like us to contact someone on your behalf, if you don’t understand what the doctor has said to you or you would like more information about your condition. There was also a sign asking people to let staff know their preferred means of communication.

As at the last inspection, we found there were a number of specialist teams available, including a frail and older person’s advice and liaison team and an older person’s ambulatory care unit who assessed and treated people who might not need hospital admission. This was still the case. Information leaflets within the Department were mainly in English but there was a facility to translate these into 137 languages. The top 4 languages were British Sign Language (BSL), Bengali, Punjabi, and Romanian. Staff told us telephone translation services were available, and face to face interpreters could be obtained.

**Meeting people’s individual needs**

The trust complied with the Accessible Information standard by ensuring that people with a sensory loss, impairment or disability were given information they can easily read or understand. If a person had attended the hospital before their communication needs would be on the patient record. A poster in the waiting room encouraged people to say how they preferred others to communicate with them, for example by using communication boards and pictures, or in another language. The department could access staff trained in sign language.

Staff said sometimes patients came with patient passports which was useful. The trust was aiming for 95% of all patients with a learning disability to have a patient passport.

The waiting room had a screen which displayed waiting times and was updated every two hours. People waiting said they found this information helpful.
There was limited space between the reception desks to enable initial patient assessments and registration to be conducted in private. Patients could potentially overhear the conversations of others registering at the same time as the windows were in a row, with little space between them. This compromised patient dignity and confidentiality, although to a lesser extent than at the trusts other emergency department. Patients registering could not be overheard by others seated in the waiting room.

Adults with learning difficulties who attended the ED had a hospital passport which assisted them to provide hospital staff with important information about them and their health when they were admitted to hospital.

ED staff showed knowledge of how to support people living with dementia, and some staff were dementia champions.

The paediatric waiting area had colourful seating and toys. There was no dedicated play specialist but the waiting times were relatively short, and children attended with their parent or carer. Nursery nurses worked as part of the paediatric ED team.

In the paediatric ED all patients with mental health needs were seen by a consultant as soon as possible. Children with special needs were prioritised at triage.

During the day the food and drinks were offered to patients in the department at mealtimes. This included hot food. We were told that there were also two hourly comfort rounds day and night where staff offered patients hot or cold drinks, although staff said sometimes when they were very busy comfort rounds were missed. A vending machine was available in the waiting room.

Relatives were able to visit a family member in ED and some patients had several visitors. If a patient was near the end of life they could be moved to a side room in majors where their family could stay with them with privacy.

There was a relative’s room for people to wait. This had comfortable seating and a television. The room could also be used for private conversations.

The area was fully accessible to those with limited mobility and was large enough to accommodate patients with wheelchairs and pushchairs.

Toilets were available for patients in the waiting area, including accessible facilities for people in wheelchairs and baby changing equipment.

The trust continued to host a 24/7 psychiatric liaison service (PLS). During the day someone from this service normally assessed patients within an hour. Staff in the mental health liaison team told us they were not allocated specific space in the emergency department for assessment. This meant if there was more than one person needing assessment, they had to use another available room to assess patients, including the relative’s room. When this happened, these rooms were not available to other members of the public.

Waiting times for patients with mental health issues could be long, out of hours. For example, the record of a patient had been bought to the emergency department by ambulance in the early hours of the morning, showed that although triage took place 20 minutes after arrival and a doctor carried out a further assessment (time not recorded), the acute crisis assessment team assessed the patient after four and a half hours. At the time of the inspection, the patient had been at the emergency department for 34 hours whilst waiting for a social care needs assessment. This was outside the control of the trust.
Mental health patients requiring admission to an acute inpatient bed typically waited in the department for seven to ten hours. Adolescents sometimes had long waits for assessment by CAMHS, for example on the day of the inspection, a patient aged under 16 had waited eight hours in the department for a specialist mental health assessment. The lack of acute psychiatric beds for children under 16 years old who required admission to the acute psychiatric unit resulted in excessive length of stay and poor patient experience. This was a risk rated moderate on the ED risk register, although much of the wait was outside the trust’s control.

The trust scored “worse than” other trusts in two out of three Emergency Department Survey questions relevant to the responsive domain and “about the same” as other trusts for the remaining question (question 11)

<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 01/09/2016 - 30/09/2016)

There were no dementia friendly adaptations in the main emergency department such as dementia clocks

The trust employed a specialist learning disability nurse who could provide additional support to patients with learning disabilities.

Access and flow

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 ED.

Staff at King George Hospital continued to be unable to meet the government’s four hour standard in the last 3 months of 2017. During 2017, 87% of patients on average were treated and discharged in 4 hours. In January 2018 they were discharging 81.3% within four hours. This performance, although below the standard, was better than at the trust’s other emergency department. However, failing to achieve the standard led to excessive waiting times for some patients and delayed decision making could impact on patient care.

On the first day of our inspection we observed some movement of patients through the department. Although at 8am 16 patients had waited overnight in ED for admission, including some more stable majors patients spent the night in minors’ bays as majors was full. During the morning, following discharges from the wards, beds were found to admit these patients. The number of majors’ patients occupying minors’ bays overnight was not affecting the flow of minors’ patients.

On the second morning patients awaiting admission occupied 11 of 16 cubicles in majors and two children were awaiting admission. Staff had only identified three available inpatient beds by midday.
The waiting times displayed for patients in the waiting room on 20 February 2018 were:

<table>
<thead>
<tr>
<th>Majors</th>
<th>7 hours</th>
<th>Adult assessment</th>
<th>20 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care centre</td>
<td>30 minutes</td>
<td>Minors</td>
<td>7 hours</td>
</tr>
<tr>
<td>Paediatric ED</td>
<td>3 hours</td>
<td>Paediatric Assessment</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

We observed walk-in patients coming in and streamed immediately to ED over a half hour period in the morning of 20 February 2018 the average time to assessment was 22 minutes. This corresponded to the length of time to assessment displayed on the information board in the waiting room. The flow seemed systematic and calm. Most patients we spoke with said they had been assessed by a clinician promptly and understood the need to wait for test results and also that patients were seen according to the priority of their needs.

It was clear that ownership of patient flow was accepted as a hospital wide issue and a collective approach was being taken. Bed meetings took place three times a day, cross site, with staff at KGH joining by telephone. The meeting involved staff from all areas of the hospital. The bed shortage was acute during our inspection due to high levels of demand on the emergency services, combined with high numbers of patients whose medical care was finished and whose discharge was delayed, despite extensive efforts by ward staff and the bed manager to identify patients suitable for discharge. If the pressures 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. Since November 2017 the trust had declared a major internal incident on five occasions because of the volume of patients and lack of beds for patients needing admission.

During this meeting, both hospitals discussed the number of patients in ED, staffing levels, any emergency department breaches and bed capacity. This allowed the trust as a whole to identify capacity issues, and ways to resolve these, although at the time of inspection there were few beds available.

We were aware that there were a number of elderly patients in wards during our inspection who were medically fit for discharge but unable to be moved for a variety of reasons, such as waiting for funding to be agreed, or for a rehabilitation bed in another trust, or a care home placement. This was outside the control of the hospital.

There were three dedicated porters in the department. Clinical staff could page them when needed to take patients to X-ray or to a ward, and the system was seen to work efficiently.

A medical assessment unit (MAU) was used to care for medical patients expected to need a short admission, less than 48 hours. ED had strong working relationships with this ward, and we were told they sometimes shared staff.

Staff told us that the department had increased referrals to the elderly ambulatory care unit since the last inspection. The frail older people’s advice and liaison (FOPAL) service patients over 75 people go home with access to the right assessment and support. An older people’s registrar, physiotherapist and occupational therapist supported this unit. Staff told us the service was invaluable in getting some patients home with support from social workers and allied health professionals, thereby avoiding admission, and reducing pressure on ED.

Waiting times for patients with mental health issues, 2.4% of adult patients and 0.6% of child patients presenting to ED were often long ‘out of hours’, although for adults assessment was usually within an hour during working hours. For example, we saw that one patient brought to the emergency department by ambulance in the early hours of the morning, had been triaged within 20 minutes, and had a further assessment by a doctor (time not recorded). The acute crisis assessment team assessed the patient after four and a half hours. At the time of the inspection,
the patient had been at the emergency department for 34 hours whilst waiting for a social care needs assessment. On the day of the inspection, a patient aged under 16 had waited eight hours for a specialist mental health assessment.

Patients requiring admission to an acute inpatient mental health bed typically waited in the department for seven to ten hours. Adolescents requiring an admission could wait up to three days for a bed to become available.

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 ED. The trust did not meet the standard on any occasion from December 2016 to November 2017.

From December 2016 to November 2017 the trust’s performance against this metric showed considerable fluctuation. Throughout this period the trust’s performance regarding the four hour waiting period was below the average for England and the NHS standard:

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

From December 2016 to November 2017 Barking, Havering and Redbridge University Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. Performance against this metric was maintained with neither improvement nor decline over the period:
Between December 2016 and November 2017 two patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over four hours were in December 2016 and January 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2016</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>January 2017</td>
<td>108</td>
<td>1</td>
</tr>
<tr>
<td>February 2017</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>March 2017</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>April 2017</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td>May 2017</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>June 2017</td>
<td>36</td>
<td>0</td>
</tr>
<tr>
<td>July 2017</td>
<td>90</td>
<td>0</td>
</tr>
<tr>
<td>August 2017</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>September 2017</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>October 2017</td>
<td>57</td>
<td>0</td>
</tr>
<tr>
<td>November 2017</td>
<td>76</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Senior staff told us they did not divert ambulances if they were busy but did keep in regular contact with the local ambulance service to inform them of their capacity.

From November 2016 to October 2017 the monthly percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average each month. However in October 2017 the trust’s performance for this improved to a rate similar to average for England. At King George Hospital about 4% of patients left without being seen which is slightly worse than the standard but better than the England average:
From November 2016 to October 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average:

![Graph showing median total time in A&E](image)

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

ED received some patients through the onsite UCC. If the GP considered a patient needed to be seen by a specialist, the GP would contact the relevant speciality and if the speciality accepted the patient, that person transferred to ED to be reviewed by the accepting team. If the patient needed a blood test or x-ray this was also arranged through ED.

Learning from complaints and concerns

At the last inspection there was limited evidence of feeding back learning from complaints to staff. At this inspection staff were open in sharing information about complaints as well as complements. We spoke with PALS staff who said there were few complaints about emergency care at King George hospital. In November 2017 ED received one example of positive feedback about the children’s emergency department, and only five complaints about ED services.
From October 2016 to September 2017 there were 140 complaints trust-wide about urgent and emergency care services. The trust took an average of 27 working days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be closed within 25-40 working days.

There were 34 complaints in the year between October 2016 and September 2017. Complainants received responses within an average of 27 days.

A breakdown of complaints for urgent and emergency care by site and subject is below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>King George Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>18</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>7</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>4</td>
</tr>
<tr>
<td>Care process</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Waiting times in A&amp;E</td>
<td>2</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td></td>
</tr>
<tr>
<td>Waiting times for IP admission</td>
<td></td>
</tr>
<tr>
<td>Waiting times for scans/tests</td>
<td>1</td>
</tr>
<tr>
<td>Safety - Accidents</td>
<td></td>
</tr>
<tr>
<td>Safety - other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*

**Is the service well-led?**

The emergency department at King George hospital was part of the acute medicine division within the trust. A clinical director, a divisional nurse and a divisional manager jointly ran the acute division. They reported to the trust board through the chief operating officer. At the last inspection there had been no lead nurse, but this post was filled on this inspection.

Both emergency departments were run by the same general manager and clinical lead. An ED lead nurse also worked across both sites. Locally, at King George hospital nurse leadership was from a matron.

Doctors and administrative staff rotated between the sites. Most nurses in this ED worked primarily at King George Hospital; although there was occasional movement of nurses between sites when needed to achieve safe staffing mix.

The trust had introduced a leaders’ agreement, launched in November 2017. This was a set of expected behaviours of trust leaders and a commitment to supporting and developing leaders locally. There had been a number of recent senior managerial appointments, mainly from within
the trust, to provide continuity. Staff said senior managers were regularly seen at King George hospital and known to staff.

We were told the trust was extending the leadership training for ward managers to shift leaders in ED.

**Vision and strategy**

At the last inspection there was uncertainty about the future of urgent and emergency care at this hospital. The regional strategic transformation plan had included the downgrading of King George Hospital to an urgent care centre, with Queen’s Hospital becoming the primary accident and emergency service. We were told the proposed downgrading of the service was now under review at regional level. Staff had been informed recently that the existing ED at King George hospital would continue to operate until the trust approved a clinical model that could provide excellent, safe patient care and meet the needs of local people now and into the future.

At the last inspection we found a lack of clarity on the vision and strategy at department level. There was still no written vision, but staff told us their aim was to provide excellent emergency care 24 hours a day, seven days a week.

There were plans for capital expenditure to improve the streaming area, although the plans had not been discussed with many staff.

**Culture**

Staff morale had been good at the last inspection and this continued to be the case. Staff who worked at both sites said they liked the ‘family’ atmosphere at this site, where the design of the unit promoted team working and good information flows. We also found the culture less hierarchical than at the other hospital site. We saw senior staff helping clear bays so they were quickly ready for the next patient.

The staff in paediatric ED were very proud of the service they offered to children and families and received complements from users on their kindness and professionalism.

Some staff mentioned the PRIDE values (Passion, Responsibility, Innovation, Drive, and Empowerment) and their impact on developing a shared culture. There were a number of mechanisms for rewarding staff for exemplifying trust values in the workplace, a friends and family team of the week, PRIDE awards and Star of the Month.

Staff described a ‘no blame’ culture in relation clinical incident reporting. They reported learning from incidents and staff were able to identify changes in practice as a result of incidents.

The response to the staff, friends and family test (trust wide) in August 2017 was 83%. 76% of staff recommended the care given at the hospital but only 59% would recommend working there.

**Governance**

There were opportunities for shared learning between the trust’s two ED sites. Doctors and some administrative staff worked cross site, but few nurses did so. However the matron had worked at both sites and brought that wider experience to her role.

One complicating factor in managing EDs located in different boroughs was that there were slightly different commissioning arrangements. Redbridge was the commissioner for King George hospital and Havering for Queens Hospital.

There had been improvements in governance in the emergency department following our previous inspection. Governance processes and structures were more clearly focused on priorities and followed set agendas.
ED held monthly joint business and clinical governance meetings and quality & safety meetings reviewed incidents, risks, clinical effectiveness, updates to NICE guidelines, and audits. Escalation from these meetings was to the divisional governance meeting. Trainee doctors attended divisional governance meetings to enhance their knowledge of governance. We reviewed minutes from monthly meetings and saw information about incidents was shared with staff through meetings, email and during handovers.

The matron had regular meetings to discuss ED activity with staff and information was cascaded through a range of communication methods such as email, newsletters and meetings.

We had concerns about governance in relation to patients with mental health issues in the emergency department which was not adequately covered in policies, guidelines or staff training. For example, the trust policy on managing violence aggression did not refer to NICE guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings. We found no reference to rapid tranquillisation in the medicines policy or injectable medicines policy, and no mention of patients presenting with mental health issues in the Children’s Emergency Department Observation Policy. There was no policy on observation of adults in the emergency department, or on the Mental Health Act. There was insufficient managerial oversight of recording of restraint and of rapid tranquillisation, including recording the legal basis for actions.

Management of risk, issues and performance

At the last inspection the main risks were the failure to achieve the four hour standard, lack of paediatric nurses and lack of ALS/APLS training. At this inspection, training on life support had been made widely available and was no longer high risk. The biggest challenge remained capacity and demand and the inability to meet the four hour standard for all patients. Insufficient medical staffing remained a high risk, although there was some mitigation from increased recruitment to permanent posts and more regular locum doctors.

Senior staff reviewed the departmental risk register monthly. On this inspection we considered the main risks were those on the trust’s risk register. The risk area that was missing related to the care of patients presenting with mental health issues in the time between triage and mental health specialists arriving, or in the period when ED staff were caring for patients for many hours whilst waiting for a transfer who might need enhanced observation. In the week of our inspection 29 patients presented with mental health issues. 21 were known to mental health services and nine presented with substance misuse. Our concerns focused on their immediate treatment and risk assessments before mental health specialists arrived or in the period when ED staff were caring for patients waiting in ED or a transfer. ED staff did not have training in managing these patients in line with NICE guidance. The lack of beds for psychiatric patients under 16 was a national issue and not within the control of the trust, but this put pressure on the trust to provide appropriate care while the patient was in their hospital.

The trust told us after the inspection that there was an action plan for ED to work alongside the local mental health trust relating to the CQUIN improving services for patients with mental health needs presenting to ED.

The chief operating officer chaired an emergency access delivery board to improve trust performance against the four hour standard. The trust had developed ED escalation plans (full capacity protocols) setting out clear pathways and processes for staff to follow when there was a failure to deliver patient flow through the department. However, the ability to effectively manage surges in demand remained amber on the risk register. Clinical staff were more focused on
providing safe care than meeting timing standards which they did not feel the department had either the physical capacity or staffing to meet.

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority. All staff were aware of this.

The site had a back-up generator supply for the loss of electrical supply, and uninterruptable power supplies (UPS) enabling them to function normally during the gap between grid failure and generator start up. Staff told us that fire alarms and the emergency generators were tested regularly.

**Information management**

The department was able to monitor performance of accident and emergency performance against the four hour standard throughout the day.

ED receptionists had to use several different IT systems. One was the hospital’s main patient information system, to check patient details and previous hospital attendances. ED had its own patient record system to monitor time and flow. The hospital admissions list was a spreadsheet, and separate to other IT systems. A receptionist explained that because the different computer systems were not interlinked, a patient could be put forward for admission on one system, and accepted for admission on a second system, thus duplicating work. Also, patients initially seen by the UCC, which used a different IT system, had to be re-registered if they transferred to ED.

ED treatment records were paper based. Staff had to photocopy all the electronic records for all patients requiring admission. Paper treatment records were not scanned onto an electronic system until archiving stage. Clinicians expressed concern that treatment information and diagnostic results held on multiple different systems made it difficult to see the whole patient picture.

**Engagement**

There was a strong spirit of unity in the staff team, which was helped by the compact layout of the department. We observed strong team working.

Staff had briefings and regular newsletters to keep staff informed. Staff received a fortnightly e-newsletter ‘Emergency Bulletin’. It covered news about the department including training, staff news and information about lessons learned from incidents, compliments, complaints and training. Doctors received a medical information newsletter.

Many staff mentioned lack of communication and consultation from non-clinical managers about changes to the environment. For example, the department used to have a male and female observation ward, but one had been taken over to become part of the new discharge lounge. Staff were aware of plans to change the streaming service and were concerned that plans would not take account of experiences of staff on the front line. Staff had also felt this way at the previous inspection, and had raised their concerns in the staff survey. They felt they were often the last to know about changes.

The trust encouraged a number of initiatives to foster engagement with the general public including: ‘you said, we did’ boards and information on the website and on twitter. A Patient Partnership Council had emergency care as part of its focus. This provided a forum for feedback. The trust also ran listening events, with Healthwatch, to focus on themes identified in Patient Advice and Liaison Service (PALS) enquiries.

Leaflets around the department encouraged patients and relatives to complete the friends and family test. Patients could also ‘share their story’ or fill in the friends and family test online.
Learning, continuous improvement and innovation

Trust wide, staff were taking some innovative approaches to improving staffing, through taking on care support workers and training them to develop as Emergency Care assistants, and recruiting apprentices to become band 2 support workers.

In the absence of funding for external training and development, staff were running internal training to build skills and capability. For example, emergency department assistants were undertaking nurse associate training and emergency care practitioners were doing physician associate training. Consultants were helping train nursing staff. The department were offering family-friendly hours and flexible working to help attract and retain staff.
Barking, Havering and Redbridge University Hospitals NHS trust provide a range of medical care services across their two main sites:

- **Queen's Hospital**: 15 inpatient wards with a total of 383 beds.
- **King George Hospital**: Eight wards with a total of 206 beds.

(Source: Routine Provider Information Return - Acute-Sites)

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

The trust had 61,123 medical admissions from September 2016 to August 2017. Emergency admissions accounted for 35,026 (57%), 1,061 (2%) were elective, and the remaining 25,036 (41%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 20,755 admissions.
- Gastroenterology: 13,711 admissions.
- Geriatric Medicine: 7,087 admissions.

(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

Across medical wards from October 2016 to September 2017 mandatory training figures for nursing staff were meeting or better than the trust’s standard of 90%, (the trust had a 95% standard for information governance).
There was an annual rolling programme of mandatory training. Mandatory training was provided either face to face in a classroom or via e-learning. Nursing staff of band 6 and above with supervisory responsibilities were responsible for ensuring staff were up-to-date with their training.

Senior staff could monitor staff training via the trust’s electronic training and professional development record. Senior staff had access to the electronic training record of staff they supervised. Staff told us the system sent email prompts when training was due to be updated.

During our previous inspection in September 2016 we found poor compliance with mandatory training for medical and dental staff. We were told at this time that this had been identified by the trust as an area for improvement. However, data provided by the trust indicated that between October 2016 and September 2017, medical and dental staff were still not meeting the trust’s standards for any mandatory training modules, with compliance rates being between 74% and 83%, this was worse than the trust’s 90% standard, (please see the mandatory training table below).

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from October 2016 to September 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>241</td>
<td>289</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>232</td>
<td>289</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>224</td>
<td>289</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>224</td>
<td>289</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>223</td>
<td>289</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>218</td>
<td>289</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>213</td>
<td>289</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was not met for any of the applicable courses for medical/dental staff.

A breakdown of compliance for mandatory courses from October 2016 to September 2017 for nursing staff is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>679</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>679</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>678</td>
<td>691</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>667</td>
<td>691</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>660</td>
<td>691</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>652</td>
<td>691</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>643</td>
<td>684</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Training targets were met by nursing staff for all applicable courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Safeguarding

Staff understood how to protect patients from abuse and the procedures for reporting suspected abuse.

Staff we spoke with had an understanding of adult safeguarding procedures. Staff told us they would ask for guidance from the safeguarding lead if they had concerns about a patient. Phone numbers and contact details for the safeguarding leads were available on the intranet, in staff rooms and ward offices.

Safeguarding training figures showed that medical staff were failing to meet the trust target of 90% for level 2 safeguarding for both adults (83%) and children (72%). Managers told us level 3 safeguarding superseded level 2 safeguarding training. Therefore, some staff that had completed level 3 training would not need to update their level 2 training. Nursing staff were achieving the trust’s 90% standard for level 3 safeguarding children’s training, but, not for level 3 safeguarding adults training (65%).

Safeguarding leads were trained to level 3 in accordance with national guidance. The chief nurse was the executive lead for safeguarding. There was also a named doctor for adults safeguarding. Staff received a monthly safeguarding bulletin via email from the safeguarding team. The deputy chief nurse told us they did walk arounds and did ‘ad hoc’ tests of staff safeguarding knowledge.

In accordance with national guidance, safeguarding was reported through a number of external bodies, for example, there was a monthly operational group meeting with the clinical commissioning group (CCG), and an annual report was sent to the trust board and to local safeguarding adults’ boards.

Safeguarding training completion rates is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Acute Medicine’ and ‘Specialist Medicine’ directorates across the whole trust.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 4</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>239</td>
<td>288</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>210</td>
<td>289</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met target for all safeguarding courses for medical/dental staff.
A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>589</td>
<td>603</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>506</td>
<td>530</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>149</td>
<td>161</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>57</td>
<td>88</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met target for all safeguarding courses except for Safeguarding Adults Level 3, for nursing staff, where the trust scored 65%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We saw some staff were not always compliant with infection control practices. For example, we saw a doctor and a nurse on Ash ward not washing their hands in between seeing patients in the bays. Hand gels were not used, although gloves were in use. We also saw clean linen in a corridor on Ash ward; this posed a risk of the linen becoming contaminated.

Senior matrons told us monitoring of IPC had improved since our last inspection in September 2016. The matrons told us the trust’s specialist IPC team were completing monthly walkabouts and audits of IPC. IPC was also monitored via the divisional performance dashboards.

The trust’s specialist IPC team lead had been in post since November 2016. The team lead told us work was in progress on a number of standard operating procedures to improve IPC practices across the trust. This included a data analyst to provide support to the IPC team.

Patients with suspected or confirmed healthcare-associated infection were nursed in isolation rooms. There was appropriate signage available to display on doors to these rooms to alert staff to use appropriate IPC techniques.

The IPC team had introduced an algorithm for staff for the early identification of Clostridium difficile, also known as C. difficile or C. diff, this is a bacterium that can infect the bowel and cause diarrhoea. The IPC team highlighted to staff early identification of patients with loose stools. IPC staff told us there had been a reduction of cases from 29 cases in 2016 to nine cases in 2017.

All patients were screened for Methicillin-resistant Staphylococcus aureus (MRSA); this is a type of bacteria that's resistant to several widely used antibiotics.

All wards had a link IPC practitioner. These were staff that took the lead with IPC, these were staff that shared information and provided formal, two-way communication between the specialist IPC team and staff on the wards.
There were ‘cleaning matters’ boards on each ward that displayed the wards cleaning schedule for domestic staff. Domestic staff worked for a provider contracted by the trust to provide cleaning services. Cleaning staff were aware of procedures to reduce the risk of infections. Isolation rooms would receive a deep clean following the discharge of a patient with an infection.

Personal protective equipment (PPE) was available for staff to use across all wards and departments. All wards had antibacterial gel dispensers at the entrances to wards and by patients’ bedside areas.

Equipment that was cleaned had ‘I am clean’ stickers attached to indicate to staff that it was clean and ready for use.

Wards had dashboards which carried information on the wards use of hand hygiene and IPC. For example, we viewed the dashboard for the medical assessment unit (MAU), dated from April to November 2017. The dashboard indicated that compliance had been below 90% in April 2017. This had improved from May to July 2017, when the MAU had achieved 100% compliance. However, from August to September 2017 compliance had again reduced to below 90%. Compliance improved again from October to November 2017, when the MAU achieved 100%.

**Environment and equipment**

Across the wards we found the ward temperatures were very hot. We asked staff how they regulated ward temperatures. Staff on the night shift on Gentian ward told us they could not regulate the temperatures as this was centrally controlled. Staff said they opened windows if the ward became too hot. Staff were not aware if there was a thermometer to monitor the ambient ward temperature. We also spoke with staff on other wards that showed us radiators fitted with thermostatic controls. However, staff told us the trust’s estates department were the only staff who could operate the thermostats. This meant staff on the wards were unable or unaware of how to regulate the temperature on the wards.

We asked the trust about temperature monitoring on the wards. They responded that ambient room temperature was being "progressed" by the trust. However, the trust did not explain how ambient room temperatures were being monitored, with the exception of rooms where medicines were stored. The response said that manual thermometers were in use. However, we did not see any thermometers on the wards and staff were only aware of thermometers in rooms where medicines were stored.

During our previous inspection in September 2016, the trust had identified breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services. However, during this inspection we found repairs had been completed and the risk had been removed from the corporate risk register.

Staff told us there were weekly ‘walkabouts’ by director of operations accompanied by the estates and cleaning services teams to enable the operations director to identify and rectify issues with the hospital environment as early as possible.

Equipment used on medical wards was clean and labelled to indicate it was disinfected and ready to use. Portable equipment had been recently serviced and labelled to indicate the next date of testing. Staff reported equipment was easily obtainable and the estates department responded in a timely way to requests for urgent repairs.
Emergency equipment was located on all wards. We examined resuscitation trolleys across medical wards and found they contained all the required equipment including: defibrillators, to manage medical emergencies such as a cardiac arrest. The trolleys we examined were secure, fully stocked and ready for immediate use.

Equipment was available for patients with pressure ulcers in line with Royal College of Nursing: Management of Pressure Ulcers: Patients with pressure ulcers should have access to pressure-relieving support surfaces and strategies. For example, mattresses and cushions were available 24 hours a day. This was in accordance with guidance from the Royal College of Nursing: ‘Management of Pressure Ulcers: All patients assessed as having a grade 1 to 2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties’.

There was a system of automatic electronic supply management for disposable equipment. The electronic system monitored stock levels and placed orders for stock when levels reached an agreed level for top up. This reduced the risk of over stock and stock becoming out of date.

There were safe systems for managing waste and clinical specimens. There were ‘sharps’ bins available in all clinical areas we visited. We found sharps bins were correctly labelled and assembled in accordance with Department of Health guidance HTM 07-01, ‘Safe management of healthcare waste’.

Staff told us the age of some equipment in diagnostics and imaging was a challenge. For example, the computerised tomography (CT) scanner was on the trust’s risk register. Staff told us the scanner was over 10 years old and was the only CT scanner on the hospital site. Staff told us the scanner had been upgraded with digital plates and was functional. Staff said the CT team would use radiotherapy scanners to manage increases in demand.

Assessing and responding to patient risk

We reviewed several patient notes across all areas of medical care. There were risk assessments in key safety areas using nationally validated tools. For example, staff assessed the risk of falls and skin integrity. Risk assessments were recorded in a patient’s booklet. Booklets were for a period of seven days, a new booklet was introduced when booklets were complete. We saw risk assessments were reviewed and repeated within recommended timescales.

We noted when risks were identified; care plans were in place to address these. For example, the risks of venous thromboembolism (VTE), (this is a condition in which blood clots form in the deep veins of the leg (known as deep vein thrombosis) and can travel in the circulation and lodge in the lungs (known as pulmonary embolism), VTE was assessed for each patient and preventative measures were in place as a result of this: such as the use of anticoagulant medicine, (medicines to reduce blood clotting), when required. However, we noted that if a patient was admitted via the emergency department (ED), a separate booklet was completed in ED. We found this confusing as some patients had an inpatient ward booklet and an ED booklet in their records, and this meant staff would spend time looking at records from both ED and the ward, as it was not easily identifiable which booklet related to which service.
All patients were risk assessed on entering any ward area for falls. Patients at risk of falls were communicated to staff using a symbol displayed on a magnetic whiteboard above patients’ beds and recorded in patients care records. There was a falls escalation process in place. We also saw patients at risk of falls were recorded on handover sheets. Staff told us where patients at risk of falls would be admitted to bays close to nursing stations so that they were visible to staff.

We saw clear pathways and processes for the assessment of people using services within the endoscopy unit. This included patients who needed a hospital admission following procedures.

The hospital had implemented an electronic early warning score and we saw this was routinely used for inpatients. This was a handheld device for recording patient observations in real time. The system reduced the time staff spent on observational tasks, releasing time for staff to provide care. Early warning scores were calculated automatically, eliminating the risk of error. The devices detected patients’ deterioration earlier and facilitated earlier escalation. This enabled early intervention without the nurse leaving the patient’s bedside. We found patients’ physiological parameters such as pulse and temperature were monitored in accordance with NICE guidance, (CG50), ‘Acutely Ill Patients in Hospital.’ The early warning score incorporated a sepsis screening tool to identify patients with sepsis as early as possible.

There had been previous incidents of sepsis and the trust had been identified as an outlier by CQC, and had since taken steps to address this. Patients admitted with suspected/confirmed sepsis were continually assessed and monitored using the electronic early warning system. We saw good adherence to antibiotics being administered within an hour, in-line with recommended guidelines. Ash ward had a training board which displayed information for staff on ‘Sepsis 6,’ a bundle of medical therapies designed to reduce the mortality of patients with sepsis. We also saw the trust’s sepsis protocol displayed on a board in Holly ward. Staff used the trust sepsis policy to support them to manage and recognise sepsis in patients. Staff we spoke to confirmed they were aware of this policy.

The trust participated in the sepsis commissioning for Quality and Innovation (CQUIN) national goals programme, (this is a system to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care). The trust achieved the goals in 2016/17. This was an improvement in the trust’s delivery of sepsis care from 2015/2016.

Consultants did daily ward rounds to assess new patients, and review the ongoing treatment plans of inpatients. There was a ward round for all patients admitted overnight on the Medical Assessment Unit (MAU). Junior doctors and consultants assessed the patient and formulated a plan of care, and were reviewed by a senior consultant within four to 12 hours. This was in accordance with the ‘Priority Clinical Standards: Standard 2, Seven day services’.

Queen’s hospital had a critical care outreach medical emergency team which could provide advice to all medical wards at KGH in the event of a patient experiencing a medical emergency. Nursing staff told us medical staff across all wards and departments were responsive to bleep calls. Out of hours junior doctors and registrars would attend bleep calls in the event of a patient deteriorating.

Patients were provided with a named wristband when admitted to the hospital for identification purposes. However, we saw a patient on Ash ward who was not wearing a wrist band. The patient told us they had not been fitted with a wrist band.
Staff had access to the hospital’s mental health team. We saw examples where patients required an urgent referral and this was arranged via the mental health lead for medicine. The mental health lead also attended board meetings to offer advice and guidance for patients experiencing mental health issues.

A summary of the number of bed moves per patient at the King George Hospital and Queen’s Hospital sites is below. The proportion of patients moving at least once increased at both sites over the two years, from 7% to 19% at King George Hospital and from 8% to 11% at Queen’s Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of moves</th>
<th>October 2015 to September 2016</th>
<th>October 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients (%)</td>
<td>Number of patients (%)</td>
<td></td>
</tr>
<tr>
<td>King George Hospital</td>
<td>0</td>
<td>2,638 93%</td>
<td>1,887 80%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>201 7%</td>
<td>454 19%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6 0%</td>
<td>7 0%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td></td>
<td>4-</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Total</td>
<td>2,845 100%</td>
<td>2,348 100%</td>
<td></td>
</tr>
</tbody>
</table>

Queen’s Hospital

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of moves</th>
<th>October 2015 to September 2016</th>
<th>October 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients (%)</td>
<td>Number of patients (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>9,624 92%</td>
<td>8,840 89%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>871 8%</td>
<td>1,105 11%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>22 0%</td>
<td>26 0%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0 0%</td>
<td>1 0%</td>
</tr>
<tr>
<td></td>
<td>4-</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Total</td>
<td>10,517 100%</td>
<td>9,972 100%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Routine Provider Information Request – Ward moves tab)

Nurse staffing

The Trust used the Safer Nursing Care Tool (SNCT) to establish the staffing requirements across wards and departments. Safe staffing boards on wards displayed staffing levels daily. For example, the staff board on Ash ward on 23 January 2018 recorded the number of staff on duty and recorded, “all staffing levels met today.” Staff on Ash ward told us the ward regularly used agency staff, with substantive staff supporting agency staff. However, a few substantive staff told us agency staff could feel like a “burden” to staff as they were not familiar with the processes and procedures on the wards, and needed advice and guidance from staff.

Nursing staff we spoke with told us qualified nurse staffing was an issue across the wards. For example, staff on Fern ward told us there were five band 5 nursing vacancies. We viewed the rotas for Fern ward for January 2018. These recorded that the ward had been understaffed by one HCA and one qualified nurse on 9 January 2018. However, staff told us overall staffing had improved in the previous 12 months. Staff also said the hospital’s own staff were more prepared to work bank shifts and this reduced the use of agency staff.
We viewed the e-roster on Gardenia ward on the 23 January 2018. This demonstrated that the ward were one qualified nurse short on the evening roster. Staff told us this was because a member of staff was absent due to sickness. The ward had tried to recruit agency staff, but, had been unable to cover the shift. The ward had covered the absent member of staffs’ shift the following day, Wednesday 24 January 2018, by asking weekend staff to work. The ward also had two shifts to cover on Thursday 25 January 2018. Staff said the ward were trying to recruit agency staff to cover these shifts. Staff told us Gardenia ward was not short staffed on a regular basis and the staffing shortages were as a result of staff sickness. Following our inspection the trust informed us that Gardenia ward had not reported staffing shortages as an incident on the 23 January 2018 and did not submit a return for the ‘red/amber’ report’ for January.’ The trust’s opinion was that staff had managed the staffing situation in accordance with the trust’s safe staffing policy.

Nursing staff on Erica ward told us staffing at night could be challenging. The ward had three planned qualified nurses at night and three HCA. Staff told us the ward were taking patients who were more confused and had higher levels of acuity. Staff said sometimes these patients received one to one care, but, often staff were expected to cope with the situation. Staff said they did not complete incident reports where patients’ acuity had put pressure on staff. Following our inspection the trust informed us that a daily acuity and dependency tool was completed and staff would move wards if the acuity was higher than planned. The trust informed us that Erica ward had submitted three staffing incident reports between 1 January 2017 and 31 March 2018, none of which had resulted in harm to patients. A ‘red/amber’ staffing report had been introduced in January 2018. Erica ward had reported one ‘red’ shift. This was for a long day and not a night shift. The trust informed us that Erica ward had also reported 23 amber shifts. The ward establishment was for three registered nurses on a night shift. Acuity and dependency recording using the Safer Nursing Care Tool did not indicate that this required a change.

The trust had a rolling recruitment programme which included advertising vacancies in professional journals and websites as well as on the trust’s website. However, managers said there was competition from other London hospitals. Work was in progress on ‘grow your own' initiatives. These were initiatives to provide pathways for staff already employed by the trust to gain nursing qualifications.

The trust reported their staffing numbers for nursing staff as at 31 September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>701.85</td>
<td>504.44</td>
<td>72%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From October 2016 to September 2017, the trust reported a turnover rate of 1.6% in medicine, which met the trust target of 13%. The overall turnover rate for all core services at the trust for nursing staff was 1.4%. The rate at King George Hospital was 0.8%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2016 to September 2017, King George Hospital reported a sickness rate of 5% in medical care for nursing staff. This did not meet the trust’s target of 2.8%.

From October 2016 to September 2017, the trust reported that 60% of shifts within medical care
were covered by bank and agency staff. Breakdowns by site were not provided by the trust.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*

**Medical staffing**

Across wards medical staff told us the medical staffing situation had improved since our previous inspection in September 2016. However, there were still high rates of locum usage. Some medical staff told us the use of locum staff sometimes compromised the consistency of patient care, as some locums would do one day in a service and then move on.

At night there was an on-call consultant and registrar. Two senior house officers (SHO), these are junior doctors, were on-site during the night. There was one SHO to cover the ED and one to cover the wards. Staff told us doctors could access the trust’s electronic early warning score from anywhere in the trust. However, staff told us the trust had experienced difficulties during some weekends covering shifts with SHOs. Staff said registrars had stayed on shift when this happened. For example, we saw a record on a whiteboard in the office of Fern Ward, which had been updated on 5 January 2018. The whiteboard recorded that there had been no SHO cover for medical outliers. Staff told us medical outliers were covered during the period, as the urology medical team had stepped in. Staff on the ward said there had been “no harm to patients.” Staff also told us this had been recorded as an incident and escalated. However, we discussed this with the divisional director who said they were aware that services were not staffed sufficiently with junior doctors at night and at weekends.

Staff on Fern ward said the hospital had managed winter pressures well during the current winter. Staff gave an example saying the ward would usually take medical outliers from the medical assessment unit (MAU) in the winter, as Fern ward had a three bedded receiving room; but, the ward had not had taken any MAU patients during the current winter pressures. Staff told us, “It's been very quiet for the past month.”

The medical director said there was recruitment and retention money available for medical staff. However, recruitment remained a challenge. The trust had introduced a range of incentives for medical staff, including rotation for staff to accommodate staff interests. The medical director told us the trust also had to consider incentives for locum staff to ensure the skills and knowledge locum staff had built up was retained by the trust.

The trust reported their staffing numbers for medical staff as at September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>306.85</td>
<td>248.00</td>
<td>81%</td>
</tr>
</tbody>
</table>

From October 2016 to September 2017, the trust reported a turnover rate for medical staff of 1.0% in medicine, which met the trust target of 13%. Overall turnover rates for all core services at the trust for medical staff were 1.2%. The rate at King George Hospital was 0.8% *(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

From October 2016 to September 2017, the trust reported a sickness rate of 1% in medical care for medical staff. This met the trust’s target of 2.8%.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*
The trust report that 86.5% of vacant shifts within medical care between October 2016 and September 2017 were covered by bank or locum colleagues.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In August 2017, the proportion of consultant staff reported to be working at the trust was similar to the average for England and the proportion of junior (foundation year 1-2) staff was higher.

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>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>34%</td>
<td>23%</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 (August 2017)

Records

Records we viewed were clear, up-to date and available to all staff providing care.

Paper records were generally kept at the nursing stations, and monitored by staff. This maintained security and prevented unauthorised access to patient records.

We looked at 14 sets of patient records which were multidisciplinary with doctors, nurses and therapists recording in a single document. Records we viewed were well maintained and easy to navigate. We found records were compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, (these are the professional regulatory bodies for doctors and nurses). However, we found one patient’s record on Beech ward where the multidisciplinary sheet for 6 December 2017 was incomplete, as only one member of the multidisciplinary team, a member of the medical staff, had completed the sheet. The sheet recorded that there were, “no nurses present,” and there was a note to say speech and language therapy (SLT) and physiotherapy assessments were, “ongoing,” but, there were no SLT or physiotherapy care plans in the patient’s record.

Patients records were contemporaneous and reflected the care and treatment patients received. For example, we saw that most care plans reflected guidance from the Royal College of Nursing:
‘Management of Pressure Ulcers’: All individuals assessed as having a grade one to two pressure ulcer should have a documented positioning and repositioning regime.

Antibiotic identification and timings were documented. When people were prescribed an antimicrobial they had the clinical indication, dose, and duration of treatment documented in their clinical record. This was in accordance with National Institute for Health and Care Excellence (NICE), (QS121), Statement 3: ‘People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record’.

We found patients specific individual needs were identified in records. We reviewed a set of notes for a patient with mental health needs, six with dementia needs, and a set of notes belonging to a patient with learning disabilities. For example, when a patient had been assessed by the mental health team, the mental health assessment, care plan, and risk assessment was accessible to all staff on the ward. This was in accordance with NICE, (QS15), Statement 12: ‘Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.’

The endoscopy unit kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. This was in accordance with guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).

Between October 2016 and September 2017, 77% of medical and dental staff in the directorate had completed information governance training. This was worse than the trust standard of 95%; during the same period 97% of nursing staff had completed the training, this was better than the trust’s standard.

**Medicines**

Medicines were stored appropriately and securely. Staff had positive relationships with pharmacy staff and could obtain medicines quickly when they were required seven days a week. The process of making sure that people were discharged with the correct medicines was robust. We did see that there were some occasions were people had not received their medicines as prescribed during their hospital stay including a medicine to treat Parkinson’s disease, a sleeping tablet, an analgesic and an antipsychotic.

We found medicines on Gentian ward and the discharge lounge were stored securely. Controlled drugs (CD) were secure and checked regularly in line with the trust’s policy and disposed of appropriately.

All medicines we saw were within date. Emergency drugs including oxygen, were safely stored, checked regularly and in date.

Venous thromboembolism (VTE) risk assessments, this is a condition where a blood clot forms in a vein, were completed.

Room temperature monitoring on Gentian ward highlighted on several occasions when temperatures exceeded 25°C. The pharmacy reduced expiry dates or removed items in response.

Fridge temperatures were monitored and action taken if out of range.

On Gentian ward staff were not always recording the date of opening on liquid medicines, for example, methadone, morphine sulphate, lactulose, and senokot.
We saw red dot stickers on medicine packets but ward staff provided a range of explanations as to what this meant. Pharmacy had not clearly communicated the purpose of the red dot system to ward staff.

We found prescribing was in accordance with trust policy and people’s allergies were always recorded on their medicine records. All staff had online access to a website widely used in the NHS for advice on how to give injectable medicines.

Staff were not using any mechanism to record the placement and rotation of medicines administered by patch to ensure that they were used correctly in line with the manufacturer instructions.

Pharmacy staff were available on ward each weekday to check the accuracy of discharge letters, supply medicines and complete medicines reconciliation which was appropriately recorded.

On Gentian ward we saw one patient’s drug chart which had omitted records for doses for quetiapine (antipsychotic) and zopiclone (sleeping tablet), on 13 January 2018, and omitted doses for adcal D3 (calcium supplement) on the 10 and 12 January 2018, there was also an omission of a rotigotine patch (for Parkinson’s disease) on the 13 January 2018. Another patient’s chart had a missed dose for co-codamol (for pain relief) on 23 January 2018. None of these gaps in medicines records had been reported as incidents.

Ward staff opened lockers for patients to self-administer medicines on request. However, a code of ‘S/A’ was used on charts; this is not a recognised code. The trust’s medicines policy 4.9.13 Definition of a Self-Administration of Medicines (SAM) programme identified the SAM as a self-administration of medication (SAM) scheme which gave training and supervision to patients, and enable as many patients as possible to leave the hospital administering their own medication correctly. The code should have clearly recorded the patient was on the SAM scheme.

Prescribing of antibiotics was appropriate and in accordance with policy. Prompts were embedded into drug charts to ensure antibiotic courses were appropriately reviewed.

Feedback on learning from incidents was given at ward meetings by pharmacy staff. Information was also cascaded to staff from patient safety summits.

Ward staff were happy with the support receive from pharmacy and the on-call service. Staff told us that pharmacy staff were approachable.

There was access to a clinical pharmacy service every weekday. Staff had access to an emergency drug cupboard and the pharmacy on-call team out of hours.

A pharmacy bulletin highlighted any safety issues and supply problems with medicines.

The discharge lounge ensured that people had all medicines in place before they were discharged. This involved not only checking medicines in the patient’s possession but also calling family or residential or nursing homes. Discharge lounge staff ensured that patients were discharged with a copy of their discharge letter. To take away ‘TTA’ packs were available on wards for common medicines to facilitate timely discharges.

Incidents

We did not receive information of the number of incidents by site from the trust. There had been 2454 incident reported by the specialist medicine division across both Queens and King George’s Hospitals between February 2017 and January 2018. Most incidents related to patient accidents and falls (511), this was followed by medicines (292) and tissue viability (292), appointments transfers and discharge (220), and workforce incidents (192).
There had been 1879 incidents reported by care of the elderly across both Queens and King George’s Hospitals between February 2017 and January 2018. Most incidents related to tissue viability (843), patient accidents and falls (314), medicines (171), and clinical care (100).

Learning from the reporting of incidents was cascaded and any changes to practice following a serious incident were implemented in a timely manner. During our inspection we saw that feedback was routinely given and staff could give us examples of learning from incidents. For example, senior staff on Ash ward told us serious incidents were discussed at ‘round table’ multidisciplinary team (MDT) meetings.

There were arrangements to ensure serious incidents were investigated promptly through a root cause analysis (RCA) and actions were taken. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes, information regarding serious incidents was shared with the matrons and sisters who then cascaded learning to staff on the wards via, handover, safety huddles and board rounds.

All staff were able to access the electronic incident reporting system to report incidents. We saw correct reporting of pressure ulcer and falls, in line with the Royal College of Nursing: Management of Pressure Ulcers: Staff told us all pressure ulcers grade two and above were documented as a local clinical incident. The matron for care of the elderly told us the service had introduced, “paired signatures,” for agency staff on body maps, this involved a substantive member of staff looking at body maps with the agency member of staff. The service had also encouraged health care assistants (HCA) to raise any concerns about skin integrity as early as possible.

All incidents were reviewed by the matron or ward sister and escalated if needed. All incidents involving skin integrity were automatically copied to the trust’s tissue viability nurse. The trust also fed back to staff on trust wide incidents via a monthly newsletter, which was e-mailed to all staff. Staff told us they were aware of the newsletter, but, some staff said they didn’t read them due to operational demands.

Patient safety alerts were issued via the Central Alerting System (CAS), this is a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the National Health Service (NHS) and other organisations, including independent providers of health and social care.

There were monthly mortality and morbidity meetings held by the medicine directorate. We reviewed minutes of these meetings and saw they reviewed crude mortality, mortality flags, and also prepared learning summaries to be shared with staff.

Staff were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

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 November 2016 to October 2017 there had been no incidents classified as a never event at King George’s Hospital. (Source: Strategic Executive Information System (STEIS))
There were arrangements to ensure serious incidents were investigated promptly through a root cause analysis and actions were taken. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes that information regarding serious incidents was shared with the matrons and sisters. The senior staff shared this leaning with staff on the wards via, handover or departmental meetings.

In accordance with the Serious Incident Framework 2015, the trust reported 49 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017. This table lists the types of incident in each location and a total.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>King George Hospital</th>
<th>Queen's Hospital</th>
<th>Location not specified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI/Infection control incident</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>8</td>
<td>18</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>5</td>
<td>6</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>18</strong></td>
<td><strong>29</strong></td>
<td><strong>2</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

**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 suggested data collection date.

Ward displayed ‘quality of care’ boards across the wards. The boards that we displayed performance data relating to patient falls, pressure ulcers, and catheter acquired urinary tract infections and venous thromboembolism (VTE). These boards also informed patients and staff on how many days had passed since the last incidence.

Data from the Patient Safety Thermometer showed that the trust reported 35 new pressure ulcers, 25 falls with harm and one new catheter urinary tract infection from November 2016 to November 2017 for medical services. Pressure ulcer rates fluctuated over the year but with higher numbers in the second half of the year. Rates of falls fell to zero between April 2017, October 2017 and the one catheter urinary tract infection reported was in December 2016.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Barking, Havering and Redbridge University Hospitals NHS Trust
We viewed the safety thermometer divisional audit for the period July to December 2017. This was red, amber, green (RAG) rated. This indicated that Fern, Holly, and Ash ward had a rate of below 95% and received a red RAG rating. All related to pressure ulcers acquired in the community, with the exception of Holly and Erica wards, each had two hospital acquired pressure ulcers in July 2017.

**Is the service effective?**

**Evidence-based care and treatment**

Patient assessments were based on national tools, such as the malnutrition universal screening tool (MUST) and the Braden scale for assessing pressure ulcer risk. Care pathways based on national guidance were in place for conditions such as sepsis and stroke. Staff demonstrated awareness of care pathways and we saw evidence of their effective use in treatment plans and nursing and medical records.

Staff had access to trust policies through the trust intranet. Policies and procedures were cross site, this meant staff at Queens’s hospital and staff at King George’s Hospital worked with the same policies and procedures. The trust’s corporate team had a ’mystery shopper’; this was a staff member who looked at policies to ensure they were within date. We reviewed a range of policies and found these were up to date.

The divisional director told us any new guidance from the national institute of health and care excellence (NICE) or Royal Colleges was reviewed at governance meetings.

Endoscopy had achieved JAG, (gastrointestinal endoscopy), accreditation, this is formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale (GRS) standards.
Nutrition and hydration

Patients were provided with enough food and drink to meet their needs and improve their health. Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other dietary requirements. For example, Ash ward had a ‘nutrition and mealtimes matter’ board on display on the ward. The board was colour coded to identify patient’s nutritional needs.

Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a malnutrition universal screening tool (MUST) which identified patients who were at risk of poor nutrition or dehydration. In line with National Institute for Health and Care Excellence, QS24 statement 1: ‘Screening for the risk of malnutrition’. All records we checked demonstrated that all MUST scores had been recorded. We noted patients who were identified as at risk, had nutrition care plans in place. Staff could request a dietician if needed, we were told on Erica ward that dieticians were easily accessible for advice or assessment. We viewed the trust’s MUST audit dated August 2017 to January 2018. We found across the wards services were mostly compliant in the period with the trust’s 90% standard.

Patients had drinks left within reach and all wards had protected mealtimes, these are periods on a hospital ward when all non-urgent clinical activity stops. During these times patients were able to eat without being interrupted. Staff also supported patients requiring assistance with eating and drinking at meal times.

We saw food and fluid intake was monitored using food charts and fluid balance charts. There was a ‘red-tray’ system in operation so all staff could identify patients who needed help eating and encouragement to drink. We saw magnetic signs on some wards indicating when a patient required assistance with eating and drinking and were seen to be unobtrusive and discreet. Adapted cutlery was available for those who needed it.

The trust had a team of clinical nurse specialists in nutrition. The team was led by a band 8a clinical nurse specialist and three band 7 nutrition specialist nurses. Staff told us the team were accessible and would advise on patients being fed via percutaneous endoscopic gastrostomy (PEG); this is a medical procedure in which a tube is passed into a patient's stomach to provide a means of feeding when oral intake is not adequate.

Pain relief

Patient pain scores were completed as part of routine observations by nurses. A system of scoring 1-10 was in use and this was used to evaluate the effectiveness of pain relief given. We saw pain scoring documented in patient notes. Appropriate actions were taken in relation to pain scoring triggers.

Patients who had difficulties communicating used picture boards. The visual analogue scale (VAS) and nonverbal pain indicator checklists were used to assess pain in those with communication difficulties.

Patients could be referred to the dedicated hospital pain team, who offered advice and support to patients who were experiencing pain. Staff told us they could bleep the pain team and they would respond quickly. Staff said the team would also provide advice over the telephone to
ward staff if a patient was experiencing severe pain; the pain team would commence preparation of pain medicines prior to arrival on the ward.

There was a detailed pain assessment chart based on the World Health Organisation (WHO) stepladder for patients in acute or chronic pain.

Patients we spoke with told us they received adequate pain relief and it was administered promptly when requested.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. For example, senior staff on Erica ward had visited a trust in the North of England to review how performance was monitored via the ‘model ward’ approach.

Information about the outcomes of people’s care and treatment was routinely collected and monitored. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit. For example all departments carried out a series of weekly and monthly audits to identify trends and themes and areas for improvement. Monthly audits included falls, hospital acquired pressure ulcers, dementia screening, MRSA and C-diff infections.

We viewed the monthly ‘quality of care’ audit results for January 2018. This is a monthly trustwide audit that measures patients clinical outcomes against defined standards to identify the changes needed to improve the quality of care. For example, the January 2018 audit reported on patients having a completed wristband for identification (99%), completed falls risk assessments (93%), risk assessments completed within 12 hours of admission (95%), patients having both lying and standing blood pressure taken (73%), individualised care plans (93%), whether the patient has had a fall during their admission (1%) and if a post fall action plan was in place (46%), and whether the patient was reviewed by a doctor within 12 hours (87%). The rate of post fall action plans was low and this could pose a risk to patients following a fall. However, following our inspection the trust informed us that the audit was a trustwide audit and the data for January 2018 involved one patient at KGH.

We viewed the ‘divisional performance review pack’ dated August 2017 had a dashboard of results from regular audits the acute medicine division undertook on a monthly basis. The dashboard was ‘red, amber, green’ (RAG) rated. We found overall good compliance for falls resulting in patient harm, with none being reported in the month; and venous thromboembolism (VTE) assessments were better than the trust target of 95%, with all wards scoring between 97% and 100% compliance, with the exception of Gentian ward at 34%.

There was a system for local audits to be formally presented at the directorate’s governance meetings and via the ‘divisional performance review pack’. This meant results and lessons learnt were shared to improve services.

The endoscopy service demonstrated compliance with British Society of Gastroenterology guidelines. As part of JAG monitoring the hospital demonstrated good audit practice in the department, for example, patient sedation levels, consent and records audits.
From August 2016 to July 2017, patients at the trust had a risk of readmission for elective admissions which was similar to what was expected and a risk of readmission for non-elective admissions when compared to the England average which was higher than expected.

Data provided by the trust indicated that patients in Clinical Oncology had an increased risk of elective or planned readmission when compared to the England average. However, Gastroenterology and Dermatology rates were similar to the England average.

- Patients in Gastroenterology and Dermatology had risks of readmission for elective admissions which were similar to expected.
- Patients in Clinical Oncology (Previously Radiotherapy) had a risk of readmission for elective admissions which was higher than expected

Data provided by the trust indicated that patients in General and Geriatric medicine had an increased risk of non-elective or unplanned readmission when compared to the England average. However, the risk was similar to the England average in Sport and Exercise Medicine.

- Patients in General and Geriatric Medicine had risks of readmission for non-elective admissions which was higher than expected.
- Patients in Sport And Exercise Medicine had a risk of readmission for non-elective admissions which was similar to what was expected

From August 2016 to July 2017, patients at King George Hospital had a risk of readmission for elective admissions which was similar to what was expected and a risk of readmission for non-elective admissions when compared to the England average which was higher than expected.

Data provided by the trust indicated that patients had a lower risk of elective or planned readmission when compared to the England average.
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in Gastroenterology had a similar expected risk of readmission for elective admissions.
- Patients in Cardiology had a risk of readmission for elective admissions lower than expected.
- Patients in General Medicine had a higher than expected risk of readmission for elective admissions.

Data provided by the trust indicated that patients had an increased risk of non-elective or unplanned readmission when compared to the England average.

- Patients in General Medicine had a risk of readmission for non-elective admissions which was higher than expected
- Patients in Geriatric Medicine had a risk of readmission for non-elective admissions which was higher than expected
- Patients in Endocrinology had a risk of readmission for non-elective admissions which was higher than expected

Results for Barking, Havering and Redbridge University Hospitals NHS Trust in the 2015/16 Heart Failure Audit were better than the England average at Queen’s Hospital for all four standards and worse than the England and Wales average for three of the four standards relating to in-hospital care.
Results for Barking, Havering and Redbridge University Hospitals NHS Trust in terms of discharge are provided in the table below. At King George Hospital, scores were largely similar to the England average for all scores except for referrals to the heart failure (HF) nurse and referral to cardiology which were higher than the England average, and the rate of angiotensin-converting-enzyme inhibitor (ACEI, medicines used primarily for the treatment of hypertension (elevated blood pressure) and congestive heart failure), on discharge which was lower than the England average. The rate of referral to cardiac rehabilitation was 0% at King George Hospital compared to a national rate of 12.1%.
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 55.4% of non-ST-elevation myocardial infarction (nSTEMI, a type of heart attack), patients were admitted to a cardiac unit or ward and 91.7% of patients were seen by a cardiologist or member of the team compared to an England average of 96.2% and 55.8%. This meant patients were less likely to be seen by the cardiology team than the England average.

The proportion of nSTEMI patients who were referred for or had angiography at King George Hospital was 89.1% compared to an England average of 83.6%. This meant patients were more likely to be referred for an angiograph than the England average.

<table>
<thead>
<tr>
<th>Hospital site</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital</td>
<td>128</td>
<td>128</td>
<td>126</td>
</tr>
</tbody>
</table>
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 32%, which was worse than the audit minimum standard of 90%. The 2015 figure was 79%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 20.4%, this is not significantly different from the national level. The 2015 figure was 27%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 61.8%, this is significantly better than the national level. The 2015 figure was 100%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 81.5%; this is not significantly different from the national level. The 2015 figure was 71%.

The one year relative survival rate for the trust in 2016 is 35.7%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

In the 2017 National Audit of Inpatient falls the Trust performed as follows:

The crude proportion of patients who had a vision assessment (if applicable) was 66% this failed to meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 55% this failed to meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 38% this failed to meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 70% this failed to meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

<table>
<thead>
<tr>
<th></th>
<th>94.5%</th>
<th>20.3%</th>
<th>92.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>King George Hospital</td>
<td>121</td>
<td>121</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>91.7%</td>
<td>55.4%</td>
<td>89.1%</td>
</tr>
<tr>
<td>England: overall</td>
<td>39,082</td>
<td>39,082</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)
The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 38%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 70%; this failed to meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust reported all falls that resulted in a hip fracture as an incident with severe harm.

We saw evidence of targeted work to reduce falls in some wards. This included improved staff training and the implementation of strategies to target the causes of falls and to protect patients from harm. However the audit data above indicated need for a significant shift in working culture in the hospital to ensure improvements were fully embedded.

The allied health professional team was leading the development of a single initial documentation project that would improve efficiency in gathering patient clinical history before they were admitted to a medical ward from the emergency department. This meant patients arrived on the ward or receiving unit with a discharge plan in place, which meant the clinical team did not need to spend as much time on this. It also meant patients were not asked the same questions on multiple occasions before documentation was better connected. In addition therapies teams had completed a ward-based pilot project to implement trusted assessments for patients who required further inpatient rehabilitation. The project had been successful and would be rolled out across all inpatient wards.

The therapies team led a collar and brace care pathway that meant patients received continuing care in the community instead of remaining in hospital for extended periods of time. The pathway resulted in improved training for staff and the implementation of an algorithm to support best practice whilst the patient was treated as an inpatient.

Competent staff

There were arrangements in place for supporting staff. New staff received an induction when they commenced their post. New staff also had a supernumerary period on the ward as part of their induction, where they were rostered separately from the established number of staff.

The trust had a nurse preceptorship programme to support newly qualified nurses, this included five study days over the course of 12 months. However, a few nurse preceptors told us they were given an induction pack on commencement of their employment and competencies were assessed and signed off by senior nurses. However, some newly qualified preceptorship nurses told us that with the exception of practical competencies, the preceptorship training was mostly via e-learning and there were limited opportunities to do any learning that was not part of the e-learning package.

In response to the high use of agency staff the specialist medicine division had a seven day local induction for new agency nurses. The care of the elderly division had introduced a seven day induction booklet for agency nurses. Agency staff also had access to the trust’s e-learning packages and were expected to complete mandatory training modules.
The trust had a range of specialist nurses, for example palliative care and learning disabilities nurses. Staff told us they felt supported by specialist nursing staff and valued their input in care provision for patients with complex needs.

New nursing staff were assigned a mentor to support them in their role. Nursing staff completed role specific competencies on appointment. Senior nursing staff and practice development nurses were responsible for signing off nursing competencies.

Staff from the infection prevention and control (IPC) team told us the trust had a specific education programme for all staff who took blood cultures. This was in response to a new standardised kit. The team told us only staff that had completed the training and been assessed as competent with the kit could take blood cultures.

Staff told us there had been a substantial reduction in the trust's training budget. Learning and development staff told us the funding for non-medical staff training had been reduced. However, learning and development staff told us they were working with staff to identify bespoke training. The learning and development team had produced a learning and development strategy, ‘writing on the wall.’ The strategy tailored learning to the needs and learning styles of individual staff, rather than a ‘one size fits all’ approach to training. Learning and development staff said work was in progress to look at different modes of delivering training due to operational demands on staff. This included ‘teaching whilst doing.’ This would involve experienced staff delivering practical training whilst working on the floor with staff.

The trust had introduced nurse apprenticeships. Learning and development staff said the apprenticeship programme had enabled health care assistants (HCA) who lived locally and worked for the trust for some time the opportunity to train as qualified nurses. The trust also had 56 staff training as band 4 nurse associates.

The trust had introduced the care certificate for band 2 health care assistants (HCA).

Sepsis awareness training had been rolled out to staff across the wards. Staff told us the sepsis training was both face to face and via e-learning.

There were faculties for junior doctors training and a teaching timetable. The General Medical Council (GMC) National Training Survey monitors junior doctor experiences of education. The most recent results available for junior doctors was the 2017 survey, where the hospital scored ‘75’ for junior doctors overall satisfaction with training, this was below the ‘79’ national average score. However, the hospital scored better than the national average of ‘47’ for junior doctors’ workload, achieving a score of ‘50’. The hospital scored the same as the national average ‘75’ for curriculum coverage.

In response to NHS improvement best practice guidelines, and a requirement that specialities had a ‘front of house’ presence, the divisional director for acute medicine told us work was in progress on a team job planning approach for doctors. This was in response to HR having limited capacity to provide support for doctors’ job plans.

Learning and development staff produced an annual education plan. Each division assessed their education needs annually as part of their annual business planning. Learning and development staff said as part of planning and resource allocation, divisions were asked to prioritise training in
the form of essential training due to the need for divisions to ensure efficiency and value for money. Learning and development would then provide training on the basis of what the division could afford and prioritise this in accordance with the divisional priorities.

Due to the way data are held on their local systems, the trust was unable to provide appraisals information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘acute medicine’ and ‘specialist medicine’ directorates across the whole trust.

From April 2017 to October 2017, 86% of staff within the ‘acute medicine and ‘specialist medicine’ directorates at the trust had received an appraisal compared to a trust target of 85%. A breakdown of appraisal rates by staff group is below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of individuals trained Apr 17 to Oct 17</th>
<th>Number of individuals required – Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Scientific and Technicians</td>
<td>7</td>
<td>9</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>21</td>
<td>24</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>631</td>
<td>705</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>330</td>
<td>403</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>211</td>
<td>240</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2</td>
<td>5</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1,202</strong></td>
<td><strong>1,386</strong></td>
<td><strong>86%</strong></td>
<td><strong>85%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

We found relevant professionals were involved in the assessment, planning and delivery of patient care. Most of the care records we saw confirmed that a range of health professionals were involved in patients assessments and care. For example, we saw evidence of appropriate referral to specialist nurses such as diabetic or tissue viability nurses. Wards had multidisciplinary team (MDT) meetings that included doctors, nurses, occupational therapists, physiotherapists and other allied health professionals (AHPs).

Nursing staff told us the medical staff were supportive and responsive. Staff told us there was generally a team work ethic on the wards and medical and nursing staff worked well together.
There were weekly MDT meetings for people with complex needs, and daily board rounds and handovers were attended by a range of specialist staff.

The care of the elderly division worked closely with local authority social workers in the joint assessment team (JAT) to provide holistic assessments of patients’ needs and avoid patients having to repeat essential information. Staff worked with the local authority social workers on discharge planning and co-ordination when patients were ready to return home.

The wards had daily safety huddles where patients were reviewed and staff updated on patients’ status, for example, patients ready to be discharged.

Staff on the wards worked with the palliative care team. The palliative care team provided advice and education for staff caring for patients with progressive illnesses. Staff told us the palliative care team were responsive to requests for advice and guidance. For example, care of the elderly staff told us about a patient whose preferred place of death was at home. Staff worked with the palliative care team on a Sunday to ensure oxygen was delivered and equipment was in place to enable the patient to achieve their preferred place of death.

Staff had access to tissue viability services, through referral to a specialist tissue viability team. There were tissue viability link nurses on the ward who attended additional training and shared this with the wider ward team.

Mortality and morbidity meetings were multi-disciplinary in their approach.

The trust had introduced Schwartz rounds; these are group reflective practice forums which provide opportunities for staff from all disciplines to reflect on the emotional aspects of their work. Some staff said they had attended Schwartz rounds. However, some ward staff said operational demands made attending difficult.

**Seven-day services**

All patients on the Medical Assessment Unit (MAU) were seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who had deteriorated. This was in accordance with National Health Service, Seven Days a Week, Priority Clinical Standard 8: ‘Ongoing review.’

Once patients were transferred from an acute area of the hospital to a general ward, they would be reviewed during a consultant-delivered ward round at least once a day, seven days a week. However, consultant visits on a Sunday were limited to patients identified on the specific handover list, not all of the patients. This meant there was a risk of patients not being seen on a Sunday.

Most wards relied on locum on-call consultant cover out-of-hours, on evenings and at weekends. Junior doctors and nurses told us on-call consultants were quick to respond and they usually arrived on site within 30 minutes.

Pharmacy services were available 9am to 5pm on weekdays, with a late service that ran until 6.15 pm. The pharmacy discharge team worked alongside the main service on weekdays, between 11am and 4pm. Weekend cover was provided on Saturdays between 9am and 2pm and on
Sundays between 9am until 12pm. An on-call service, shared with Queen’s hospital, was available out-of-hours.

Diagnostic imaging provided a 24-hour, seven-day service with a combination of extended days and on-call cover after midnight. CT and MRI ran extended days during the week and at the weekend. Staff reported no issues with accessing diagnostic tests out-of-hours.

**Health promotion**

Both the deputy chief operating officer (COO) and divisional director for acute medicine highlighted the work the trust had done on providing information to patients. For example, the trust had provided a range of leaflets for patients and carers covering a broad array of topics. All leaflets were available on the trust’s website. We also saw information leaflets were available in the hospital reception and on the wards. Although the health promotion materials reflected a wide range of conditions and needs, there was no dedicated information relating to sexual health and HIV. We spoke with the HIV consultant and lead nurse for sexual health at Queen Hospital who said such information was usually only provided in the sexual health clinic. However, they said they would explore the possibility of improving resources on this topic.

Staff told us information leaflets could be requested in a range of formats from the trust’s accessible communications team. We also saw some leaflets were available on the wards in ‘easy read’ format. For example, care of the elderly wards had ‘easy read’ guides to the mental capacity act.

Patients’ independence was encouraged and promoted by occupational health and physiotherapists who worked with patients on activities of daily living (ADL).

Multidisciplinary teams involved with discharge planning gave patients advice and structured plans on health improvement after they left the hospital. This ranged from informal information based on their health behaviours to structured rehabilitation and health improvement plans.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment.

We observed staff gaining consent from patients prior to providing routine care and treatment, such as washing or adjusting their beds. However, on one occasion we saw a nurse remove a cannula from a patient on Erica ward without having a sharps box to place the used cannula in, and without gaining verbal consent from the patient.

We saw evidence in patients’ notes that there were systems in place to obtain consent from patients before carrying out a procedure or providing treatment on the wards. However, in our previous inspection in September 2016 we found there was no extension to a DoLS ‘urgent authorisation’ present in a patient’s notes on Beech ward. During this inspection we again found a patient who did not have a printed copy of an extension to an urgent DoLS authorisation in their notes on Holly ward. The matron contacted the safeguarding team. The safeguarding team forwarded a copy of the extension to the matron and this was placed in the patients notes. However, any documentation relating to DoLS should be placed in patients notes in a timely
manner to ensure staff are aware of patients they are authorised to detain under DoLS and avoid patients being unlawfully deprived of their liberty.

Across the specialist medicine and acute medicine directorate mandatory training for Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) completion rates were worse than the trust's 90% standard for both nursing (67%) and medical and dental staff (31%).

Some staff we spoke with were not sure of their responsibilities in relation to the MCA and DoLS. For example, a senior member of staff in Radiology told us they would not make a best interest decision and had not received recent training in the Mental Capacity Act. The senior staff member told us staff would have an expectation that the wards would deal with any mental capacity assessments or best interest decisions prior to patients’ being referred to the service. However, guidance from the Society of Radiographers, ‘Consent to imaging and Radiotherapy Treatment’ indicates that staff working in imaging and radiotherapy should inform patients of the nature and purpose of procedures and where a patient lacks capacity, “the key factor for radiographers is that the requirement of the Act establishes that primacy is given to the “best interests of the person lacking capacity” and this forms the basis for any treatment decision. Section 64(1) of the Act makes it clear that treatment includes diagnostic or other procedures.’ It is the responsibility of staff to ensure that any services provided have documented evidence that it is being provided with the patient’s full consent or documented evidence, or where a patient lacks the capacity to make an informed decision that it is being provided in the person’s best interests in accordance with the principles of the MCA.

Senior nursing staff told us MCA and DoLS training used to be part of the trust’s adults safeguarding training, but, this had not been robust. In response the trust were rolling out MCA and DoLS training as part of dementia workshops. Staff were responsible for booking themselves onto the training. For example, on Erica ward we found 11 out of 30 staff had completed the training. Senior nursing staff told us other staff were booked to attend the training, but, could not provide figures for this at the time of inspection.

The deputy chief nurse told us the trust were not meeting the clinical commissioning group (CCG) 85%, 2017, year-end trajectory for MCA and DoLS training. However, the chief nurse said the trend was improving. For example, the trust wide percentage of staff trained in MCA and DoLS in October 2017 was 62%; in December 2017 this had improved to 78%. In January 2018 the figure was 81%.

The safeguarding and mental health team supported staff to care for patients with mental health issues. Staff reported they would contact these teams if they had any questions around a patient’s capacity to give consent or concerns about a patient’s mental health. All incidents and deaths of patients with known mental health issues were discussed at mortality and morbidity meetings. The trust also had a MCA and DoLS advisor. Staff on the wards told us they could contact the advisor for advice and guidance on the MCA and DoLS. The deputy chief nurse told us the MCA and DoLS advisor checked patients' notes to ensure patients who lacked capacity were not overlooked.

We spoke with the deputy chief nurse who told us the trust had seen an increase in DoLS applications from 699 in 2016 to 770 from April to December 2017.
The trust set a target of 90% for completion of Mental Capacity Act and Deprivation of Liberty (MCA/DOLS) training. A breakdown of compliance for safeguarding courses from October 2016 to September 2017 for medical/dental and nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>89</td>
<td>291</td>
<td>31%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>471</td>
<td>701</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients; we witnessed these being discussed in relation to their care needs. For example, we saw a patient receiving a visit from a vicar. The vicar offered blessings to other patients in the ward.

We spoke to 10 patients across several areas in medical care. Most reported feeling well cared for. Patients reported, “The staff on the whole are excellent,” other patients told us, “In general they are kind,” and, “It’s my first time in hospital, and it’s literally been a good experience. They all have a laugh with you.”

Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. We saw kind interactions from all medical staff across the wards. Staff were seen to be encouraging, sensitive and supportive towards patients when discussing patients’ needs. However, a patient on Erica ward told us, “Most of the staff are delightful; but, there is one. I wouldn’t talk to anyone the way she does, let alone an 84 year old. But I think they are over stretched.”

We saw staff providing sensitive care to an older person on Erica ward. Staff supported and comforted the patient who appeared distressed, this was followed up by staff returning to check on the patient to gain assurances they were not in a state of distress. A patient also told us how ward staff protected their privacy and dignity by ensuring their modesty was protected.

We saw staff introducing themselves to patients and their careers in line with National Institute for Health and Care Excellence (NICE), (QS15), Statement 3: ‘Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team’.
We viewed the endoscopy patient satisfaction survey dated June 2017. This reported that 83% of patients said that they were treated with dignity and respect, none of the patients who responded to the survey said they were not treated with dignity and respect:

On discharge a Friends and Family Test (FFT) survey was given to patients and their family/carers to enable them in feeding back to the trust.

The Friends and Family Test response rate for medicine at trust level was 33% from November 2016 to October 2017. At King George Hospital the response rate was 46% and at Queen’s Hospital the response rate was 30%, all rates better than the England average of 25% from November 2016 to October 2017.

### Friends and Family Test performance by ward

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg. Resp Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resp 16</td>
<td>Resp 17</td>
</tr>
<tr>
<td>Clinical Diagnostic Unit</td>
<td>3,925</td>
<td>35%</td>
</tr>
<tr>
<td>Juniper Endoscopy Unit</td>
<td>1,958</td>
<td>70%</td>
</tr>
<tr>
<td>Sunflower Suite</td>
<td>1,608</td>
<td>10%</td>
</tr>
<tr>
<td>Ambulatory Care Unit</td>
<td>1,469</td>
<td>19%</td>
</tr>
<tr>
<td>Gardenia Ward</td>
<td>976</td>
<td>72%</td>
</tr>
<tr>
<td>Elderly Receiving Unit</td>
<td>928</td>
<td>72%</td>
</tr>
<tr>
<td>Harvest Ward A</td>
<td>925</td>
<td>49%</td>
</tr>
<tr>
<td>Angio Suite</td>
<td>772</td>
<td>76%</td>
</tr>
<tr>
<td>Ocean Ward A</td>
<td>761</td>
<td>41%</td>
</tr>
<tr>
<td>Cedar Centre</td>
<td>752</td>
<td>20%</td>
</tr>
<tr>
<td>Sahara Ward B</td>
<td>736</td>
<td>59%</td>
</tr>
<tr>
<td>Sunrise Ward B</td>
<td>673</td>
<td>88%</td>
</tr>
<tr>
<td>Medical Assessment</td>
<td>666</td>
<td>32%</td>
</tr>
<tr>
<td>Fern Ward</td>
<td>649</td>
<td>82%</td>
</tr>
<tr>
<td>Amber Ward B</td>
<td>596</td>
<td>52%</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>520</td>
<td>72%</td>
</tr>
<tr>
<td>Gentian</td>
<td>494</td>
<td>52%</td>
</tr>
<tr>
<td>Mandarin Ward B</td>
<td>483</td>
<td>39%</td>
</tr>
<tr>
<td>Sunrise Ward A</td>
<td>471</td>
<td>57%</td>
</tr>
<tr>
<td>Bluebell Ward B</td>
<td>469</td>
<td>30%</td>
</tr>
<tr>
<td>Bluebell Ward A</td>
<td>435</td>
<td>40%</td>
</tr>
<tr>
<td>Clementine Ward A</td>
<td>409</td>
<td>36%</td>
</tr>
<tr>
<td>Harvest Ward B</td>
<td>365</td>
<td>74%</td>
</tr>
<tr>
<td>ASH Ward</td>
<td>347</td>
<td>37%</td>
</tr>
<tr>
<td>Clementine Ward B</td>
<td>282</td>
<td>32%</td>
</tr>
<tr>
<td>Beech Ward</td>
<td>96</td>
<td>81%</td>
</tr>
<tr>
<td>Sky Ward A</td>
<td>87</td>
<td>56%</td>
</tr>
<tr>
<td>Holly</td>
<td>60</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Key**

<table>
<thead>
<tr>
<th>Highest score to Lowest score</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

**Emotional support**
Most patients we spoke with were very positive about the support they received from members of the MDT. The hospital had access to specialist nurses that could offer additional support and advice for example, for patients with chronic conditions such as diabetes or cancer.

Patients were screened for anxiety or depression on admission. Staff had access to support from the psychiatric liaison team and had access to agency mental health nurses for patients requiring 1:1 care.

Psycho-oncology services and complementary therapies were on-site for cancer patients. There was also access to drug and alcohol counselling.

The trust had a multi-faith chaplaincy service. The chapel/multi-faith prayer room was open 24 hours a day. Visits to wards were also undertaken and offered listening and support to patients whether they practiced a formal religion or not. The chaplaincy team supported patients, relatives, friends and carers through difficult times, Chaplains represented several major religions including Church of England, Baptist, Roman Catholic, Islam, Judaism, and Sikhism.

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

Staff involved patients and those close to them in decisions about their care and treatment.

Family members and carers were involved in all discussions around patient care. We witnessed family involvement being discussed at board rounds, multidisciplinary meetings, handovers and with patients.

Family members we spoke with were positive about how staff involved them in their relatives’ care and treatment and discharge processes. For example, a family member told us, “I can ask them about anything. They have been very good at explaining what they are doing and why.”

Patients were given time to ask questions when being told about care and treatment options in accordance with National Institute for Health and Care Excellence, QS15 Statement 4: ‘Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.’ For example, a patient told us, “You can ask them anything. I know I am being discharged tomorrow. They told me today.”

Staff on Fern ward told us they had a monthly ‘vintage tea party.’ Patients, carers and the MDT team were invited to attend. A staff member told us, “It brings staff and patients and their families together to socialise informally. The patients love it.”

The endoscopy satisfaction survey dated June 2017. This reported that over 75% of patients were happy with the written information sent to them which included instructions for their procedure and directions to the unit. 87% of patients reported that they understood the risks associated with their test.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The trust had a two year operational plan 2017-2019. This detailed the clinical strategy from 2017 to 2019. The plan outlined two-year growth profiles based on demographic and non-demographic growth assumptions detailed in the north east ‘Sustainability and Transformation plan’ for the trust’s three local Clinical Commissioning Groups (CCGs) (Barking and Dagenham, Havering and Redbridge). For example, the plan identified the top five service developments; these included the recruitment of additional staff and medical and pathology equipment replacement.

The trust were reviewing service provision at both Queens Hospital and King George’s Hospital. Senior divisional managers told us this involved Queens hospital becoming a ‘hot’ site and King George’s Hospital becoming a ‘cold’ site specialising in the provision of care for older people. Staff told us the trust’s hospitals would work with the current district general hospital model until the outcome of a five year plan review was known. Staff told us the review was in response to increased demand at both hospitals and patients with higher levels of acuity. Staff said a “frailty village” model had been proposed. However, this had met local opposition.

We discussed length of stay with the divisional director for acute medicine. The director told us they were not “fully sighted” on patients’ length of stay. The director said the hospital had a “geriatrics issue,” based on the trust’s inability to recruit specialist geriatric doctors. The director said the trust were offering enhanced packaged of support for consultant geriatricians to attract staff. For example, the trust had recruited a locum geriatrician who was moving to a substantive employed position with the trust in 2018.

The director said the clinical commissioning group (CCG) and board tracked re-admission rates. However, we were told community services had vacancies among GP and district nurses and this had an impact on patients being re-admitted to hospital. However, the director said the hospital could do more to work more “holistically” with community services.

There were organisation and divisional winter pressures plans in place. The care for the elderly matron told us the hospital did not have ‘step-down’ wards as part of winter pressure planning, as winter pressures were managed on the wards. This was confirmed by the trust who informed us that there had been no use of escalation beds at King George’s Hospital in the previous 12 months.

Volunteers were readily available at the hospital entrance and at key locations throughout the building to help patients and visitors navigate. We found signage was clear and maps of the hospital were up to date and easy to navigate.

We monitored call bell response times on Ash ward and found that in the afternoon between 3pm and 4pm on the 24 January 2018. We found staff responded to three call bells, and all were responded to within a minute. However, two patients on Erica ward and a patient on Ash ward told us the night staff were not timely in answering call bells. Patients told us this was due to night staff being busy with other patients or paperwork.

We met divisional leaders who told us there had been improvements in the average length of stay for most patients. For example, during our inspection in September 2016 we found the average length of stay for all elective and all non-elective patients was higher than the England average.

From September 2016 to August 2017 the average length of stay for medical elective patients at King George Hospital was 2.9 days, which was lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.5 days, which was higher than England average of 6.6 days.
For elective specialties:

- Average length of stay in Gastroenterology is lower than the England average.
- Average length of stay in Cardiology is higher than the England average.
- Average length of stay in General Medicine is higher than the England average.

**Elective Average Length of Stay - King George Hospital**

For non-elective specialties:

- Average length of stay in General Medicine is higher than the England average.
- Average length of stay in Geriatric Medicine is lower than the England average.
- Average length of stay in Endocrinology is similar to the England average.

**Non-Elective Average Length of Stay - King George Hospital**

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

There were arrangements to ensure when a patient required one-to-one care this was provided and additional staff were recruited to provide this.

Fern ward was an acute elderly unit, and Elm and Erica wards provided acute post-operative orthogeriatric rehabilitation. Patients had access to medical staff including a consultant with specialist interest in dementia and delirium. Staff used a cognitive assessment tool to identify patients with memory loss on admission. Patients had access to specialist dementia and delirium clinics, as well as a memory clinic in the outpatients department.
We saw suitable equipment was available for patients living with dementia or with limited mobility. Bathrooms and toilets were suitable and there were adequate supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients.

The trust had done a lot to improve dementia care since our previous inspection. Care for the elderly wards had adopted the ‘Butterfly Scheme.’ The scheme provides a system of hospital care for people living with dementia. We saw the scheme in operation across care for the elderly wards. There were also two full-time dementia support practitioners’, these were staff with enhanced training and skills in dementia care. There were also seven dementia champions in the care for the elderly wards. We also viewed patient records in Beech ward and saw ‘This is me’ documents had been completed, this is a tool for people with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes.

Work was in progress on Holly ward to roll out unrestricted visiting for carers. Carers visiting relatives on Holly ward would receive a ‘carer’s card’ that would also give the carers 15% discount in the hospital restaurant.

A learning disability liaison nurse was available to offer advice and help with care plans. Ward staff told us they would alert the learning disability nurse when patients were identified as having a learning disability. The learning disability liaison nurse was also able to make referrals to specialists who could confirm diagnosis for example, autism services and psychologists.

On the wards we saw staff did daily care rounds, these were documented in patients notes. They asked if the patients were comfortable, pain free or had any nutritional needs. Ward areas displayed photo-boards of staff uniforms so patients and their relatives could identify staff and their job roles.

Patients reported feeling supported during referral and transfer between services and discharge. We spoke with a patient who had been transferred from Queen’s hospital to a KGH medical ward. They reported they were informed when and why the transfer was happening. We also witnessed several multidisciplinary discussions around discharge and the services complex patients would need once at home, for example the joint assessment and discharge team (JAD) would visit patients who required medical care at home to facilitate patients being discharged from hospital.

We saw key staff worked across services to coordinate people’s involvement with families and carers, particularly for those with multiple long-term conditions such as dementia. The JAD team worked with social services and local services to aid discharge to care homes or to patients’ homes with care packages in place.

We saw arrangements put into place that took account of patients’ individual needs when being discharged. This included patients with complex health and social care needs that required special considerations, for example older people with dementia or co-morbidities. The JAD were accessible throughout the day.

The service offered both face-to-face and telephone interpreting services for patients that did not speak English. Staff told us they could book interpreters when required or would ask staff who spoke the patients’ language to interpret. Staff told us work was in progress for signage at the hospital to be provided in a range of languages most commonly used by patients. In our previous
report in September 2016 staff told us they often used family members as interpreters. We highlighted how this practice might compromise patients care. However, during this inspection staff we spoke with told us this practice had ceased.

We found the service compliant with accessible information standards by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability / sensory loss. There were several means to aid communication with patients with learning disabilities or dementia. These included easy read pictures that could be made into documents, easy read books on a number of conditions and hearing loops were available. Chaperones were available for patients who were uncomfortable being seen by a member of staff of a particular gender or if patients were concerned or anxious.

Staff on Erica ward told us the ward told us the learning disabilities team could arrange independent mental capacity advocates (IMCA) for patients with learning disabilities. IMCA are a legal safeguard for people who lack the capacity to make specific important decisions: including about serious medical treatment options.

Activities were provided on Elm and Erica ward. We saw a hairdresser providing hair care for patients on Erica ward. Staff told us there was a charge for the service. However, patients were positive about the service. Patients also had access to a TV, tablet computer and radio. However, two patients we spoke with told us they were not aware that they could request these. For example, one patient said, “I haven’t seen sight of a TV or radio. I didn’t know there was one.” Patients had access to a range of board games. We saw two patients’ playing cards during our inspection. A patient also told us about a ‘sing-along’ patients had been involved in.

Access and flow

We attended the bed management meeting on the 24 January 2018. This was a cross-site video linked teleconference with Queen’s hospital and the KGH site team coordinators. The meeting reviewed the hospital’s demand and capacity by ward. The meeting discussed medical outliers on the wards, of which there were 13, and patients ready or potentially ready for discharge. The meeting also reviewed consultant cover. The full capacity protocol was discussed, but had not been implemented. Two patients who were being transferred, to their local hospital in Essex were discussed. The meeting addressed areas of concern in regards to bed management at the hospital. However, due to the video link it was not always possible to hear what staff at Queen’s hospital were relaying back to staff at KGH.

The management of medical outliers was based upon guidance from the Department of Health (DoH) and Healthcare Quality Improvement Partnership (HQIP). The divisional director told us the management of outliers was an area where the hospital had made particular improvements. The divisional director highlighted that outliers were prioritised at bed meetings; and a daily rota identified which medical staff would review outlying patients.

The endoscopy patient satisfaction survey dated June 2017 reported that 55% of patients said they were not offered a choice of date and time of test. However, a further survey was conducted in October 2017 and the percentage of patients reporting that they had not been offered a choice of date and time of test had reduced to 48%. In June 2017 33% said they had a delay before their test, this had reduced to 30% in October 2017.
The hospital had a band 8b patient flow lead that was responsible for the three daily operational bed meetings and took the lead with patient discharges. The patient flow lead reported directly to the director of operations and chief operating officer (COO). Staff told us bed management had improved and there was a team approach to managing the availability of beds. The trust had introduced a ‘bed declaration’ this involved wards declaring the availability of beds. All vacant beds were reported to the bed manager.

The trust were piloting doctors using dictation devices to dictate discharge summaries, which were typed by medical secretaries to speed up the administration of patient discharges. This was a recent initiative and data was not available for us to comment on the success of this pilot.

The referral to treatment rate remained steady between 88% and 73% but below national average.

(Source: NHS England)

The NHS Constitution gives patients the right to access services within maximum waiting times. This is within 18 weeks for non-urgent conditions.

One specialty was above the England average for admitted RTT (percentage within 18 weeks). This was cardiology which scored 92.9% compared to the to the England average of 83.5%.

Six specialties were below the England average for admitted RTT (percentage within 18 weeks); details of all specialties are below.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>Average for England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>80.7%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>76.2%</td>
<td>94.1%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>92.9%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>75%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>69.2%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>68.9%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Learning from complaints and concerns**

Senior staff from the specialist medicine division told us the main area for complaints was the attitude of staff. In response the division were offering a local complaints resolution service, where patients or carers could discuss issues with senior ward staff with a view to resolving complaints early. The patient advice and liaison service (PALS) visited wards to speak with patients and offered patients support in resolving issues.
Staff told us the clinical governance team had oversight of all formal complaints. Staff said the team would prompt staff on meeting timescales for the resolution of complaints.

We viewed two complaints and found these had been responded to in accordance with the trust’s policy. However, we noted that both of the complaints raised issues about the availability of medical staff at King George’s Hospital.

From October 2016 to September 2017 there were 258 complaints about medical care across trust hospital sites. The trust took an average of 27 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 40 working days. King George Hospital medical care had 50 complaints; these were answered within an average of 29 working days before they were closed.

A summary of complaints within medicine by subject and site is below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Cross site</th>
<th>King George Hospital</th>
<th>Queen’s Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1</td>
<td>28</td>
<td>122</td>
<td>151</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>6</td>
<td>22</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Communication</td>
<td>4</td>
<td>19</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Care process</td>
<td>3</td>
<td>16</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Waiting times for appointment</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Safety - Accidents</td>
<td></td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Care General - Nursing Midwife</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Safety - other</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Facilities and equipment</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Safety - Assaults etc</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Waiting times for IP admission</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Waiting times for scans/tests</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1</strong></td>
<td><strong>50</strong></td>
<td><strong>207</strong></td>
<td><strong>258</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The trust had flow charts which clearly detailed the lines of accountability from ward to board for both the specialist medicine and acute medicine divisions. Divisional performance review meetings involved divisional triumvirate leadership teams, (divisional director, divisional nurse, divisional manager). The divisional team met with the executive directors on a monthly basis to review across the five themes of the NHS Improvement ‘Single Oversight Assurance Framework’

Managers on the wards told us the chief nurse was approachable and supportive. For example, staff told us wards managers were doing the ‘elements’ leadership training and this had been an initiative of the chief nurse.
Staff told us the chief executive officer (CEO) was visible and did regular ‘walk arounds.’ The CEO also held breakfast sessions staff could attend. Staff also told us that ward level were supportive.

Senior managers told us leadership had improved. However, senior managers said there had been weaknesses in the relationship between the divisional clinical leadership and the trust's executive board. Senior managers said the clinical leadership and board could improve their “channels of communication.”

The trust had a specialist medicines division. Although, care of the elderly sat with the acute medicines division.

The divisional director for acute medicine told us they had ring-fenced managerial time; but, if the service had a consultant shortage, then the divisional director would prioritise working clinically over managerial tasks. The divisional director had five sessions a month for management tasks. However, they were “frequently” called to do operational tasks during their managerial time. The divisional director told us as a clinician they were clinically focused and this was their priority.

The divisional director told us the hospital needed to focus on the medical staffing position. The divisional director said the hospital were creating ‘creative job plans’ for doctors to encourage staff retention, these were customised job plans that facilitated medical staff in pursuing areas of interest as well as meeting the service needs of the hospital.

Vision and strategy

Staff we spoke with were aware of the trust’s values. These were embedded within services. 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. The values had been developed in partnership with Virginia Mason Institute (VMI); this was part of a five-year partnership whereby five NHS trusts were being supported by VMI to develop a ‘lean’ culture of continuous improvement which puts patients first.

The trust had introduced an “improvement portfolio”. The senior responsible owner (SRO) for the improvement portfolio was the CEO. The improvement portfolio outlined what the trust should do and must do to improve. The first two improvement areas (or ‘value streams’) were launched in 2016; these included ‘the first 24 hours for frail, elderly patients, and diagnostics processes. These value streams were continuing in 2018. The trust ‘operational plan’ dated December 2016 detailed that the trust anticipated being able to manage four value streams concurrently, potentially rising to five as training on the improvement methodology was rolled out. For example, in 2017-2018 a value stream was focusing on the trust’s discharge processes.

Work was in progress on a five year vision for both the trust’s hospitals. Senior managers told us the trust’s vision for King George’s Hospital (KGH) in the short term was how the hospital could support increased demand and higher acuity patients. The hospital had a three year clinical strategy. However, staff said they were reviewing the strategy in response to demands on the hospital in the previous 12 months. The clinical services strategy set out a five year strategic vision which proposed for King George’s Hospital to become a centre of excellence for elective care, long-term conditions and care of the elderly.

We viewed the care of the elderly five year strategic vision. The strategy set out the priorities for care of the elderly in one to two years and three to five years. For example, one to two year priorities included, the ‘promotion of home first’, this was a ‘philosophy’ to prevent avoidable
admissions. Three to five year priorities included the provision of an academic unit for care of the elderly.

Senior matrons from both the care of the elderly division and specialist medicine division told us services had improved; but, they recognised they were on a “journey.” Both nursing and medical staff highlighted staffing levels as the area still requiring improvements. All the staff we asked about staffing told us staffing levels were the main issue with the trust. There was a high use of both locum doctors and agency staff.

**Culture**

A manager said many staff at the hospital lived locally and viewed the hospital as “their hospital.” The same manager told us staff had experienced a lot of change with the hospital’s executive team and some staff felt that each time there was a change in the trust’s executive the staff had to adapt to new ideas. However, the same manager told us there was a desire from the staff to improve services for patients.

Overall, staff reported a friendly atmosphere at King George’s Hospital. Most staff we spoke with spoke positively of their local teams, speaking of the positive changes that had occurred since our inspection in September 2016. For example, some staff talked about the hospital having a “family” feeling.

Staff told us there was a ‘no blame’ culture in response to incidents to facilitate staff learning and service improvements. Staff were aware of whistleblowing procedures; these are procedures where staff can expose any kind of information or activity that is deemed illegal, unethical, or not correct within an organization without the fear of recrimination.

Staff told us the HR department had done a lot of work with black and minority ethnic (BME) staff. There was a board lead for workforce equality, diversity and inclusion. The trust produced an annual report in response to the Workforce Race Equality Standards (WRES).

**Governance**

Governance processes fed from ward to board via a range of specialist medicine and care of the elderly divisional meetings. Divisions provided a monthly integrated quality report to the trust executive committee, quality assurance committee and trust board, which included the analysis of key themes for learning and improvement. For example, divisional governance meetings reported to the trust’s quality governance steering group on a monthly basis. There were monthly performance meetings which were attended by divisional leads, the chief nurse, director of finance, and chief operating officer (COO). Divisional leads presented their dashboards to senior leaders at the meetings. An action plan was formulated at each meeting and monitored at subsequent meetings.

The trust executive committee discussed workforce, performance and financial indicators, attendees included (executive directors, divisional directors, and corporate leads for finance, workforce and quality)

The trust board performance report was reviewed at every trust board meeting. The report was aligned with the NHS improvement ‘Single Oversight Framework’ and divisional performance reports.
Specialities had their own local quality and safety meetings. The outcomes from these meetings fed into divisional quality assurance board meetings. There was also a separate risk management group that fed into the divisional quality assurance board meetings, as well as a health and safety group which had a decontamination sub-group which reviewed infection prevention and control.

There was a weekly ‘patient safety summit’ which was led by the medical director or the chief nurse. The meeting regularly reviewed incidents, infection prevention and control, medicines safety and safeguarding issues. The meetings fed into the quality assurance board meetings.

There were regular senior nurses meetings, as well as divisional and ward meetings where risk and governance issues were discussed with a wider staff group. The frequency of these meetings varied across divisions, with some specialties or wards meeting weekly, and some meeting monthly or quarterly.

Senior staff were able to tell us how their ward’s performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for each ward.

A review of clinical audit was undertaken as part of the 2016/17 internal audit plan. In response to this the trust created a team to manage and promote clinical audits. This was led by the deputy chief nurse (quality and safety) and associate medical director (quality improvement), whose focus was on putting systems in place and to raise the profile of clinical audit throughout the trust.

The divisions had an audit calendar, which was used to monitor services and compliance against national and local standards. Nursing staff participated in local audits. Audit information was shared with teams. Senior nursing staff told us they could see how audit information could be used to drive improvements.

**Management of risk, issues and performance**

Each division had a risk register. The risk register was reviewed as part of divisional performance review meetings. We viewed the care of the elderly and specialist medicine risk reports dated February 2018. The risks on the risk registers were red, amber, green (RAG) rated. The care of the elderly ward had two red risks on the register. On the 24 July 2017 staff vacancies across care of the elderly wards was added to the risk register. On the 5 February 2018 the risk register recorded that bi-weekly recruitment meetings were taking place. The register also recorded that the trust had been unsuccessful in recruiting staff, even though a “vigorous” had been conducted. The other red rated risk related to Gentian ward, (please see the responsive section of this report).

Divisional board meetings had introduced quarterly risk review meetings to review risks on the divisional risk register and consider whether risks should be added to the register. For example, the divisional board meeting minutes dated 18 January 2018 reviewed the “inadequate” quality of the scopes at King George’s Hospital. The minutes recorded that the controls and actions in response to the risk were being investigated by the speciality. However, the minutes did not identify whether an alternative source of procurement had been identified.

We viewed the risk register for specialist medicines dated February 2016. This was divisional and covered risk at both Queens Hospital and King George’s Hospital. There was one red rated risk on the register relating to the “inadequate quality of scopes.” The scopes were not high definition. An action plan was in place to address the risk, with consultants being asked to re-book patients at
Queen Hospital which had upgraded scopes as a result of a public finance initiative (PFI). The risk register recorded that King George’s Hospital required an alternative procurement process to replace the scopes.

On the 19 July 2017 staffing on Gentian ward had been added to the care of the elderly risk register due to “potential harm to patients due to mixed specialty care of elderly people and gastric patients.” The risk register recorded that 10 gastric beds had been placed on Gentian ward. The register recorded that this posed a risk as, “the complexity of gastric patients and side effects of their conditions is likely to have an impact of the therapeutic environment for older people.” The risk register recorded actions the service were taking to mitigate this risk, on 19 January 2018, as “incidents continue to be monitored and reported at divisional and trust level.” However, the risk register also recorded that there were gaps in the risk control measures as, “If the demand is high, there can be 18 gastro patients on the 30 bedded ward.” The risk register did not include any detail on what actions were being taken to mitigate risks to patients during periods of high demand.

The trust’s medical director was the lead for mortality at the trust. The trust had recently formed a mortality faculty and adopted the Royal College of Physicians (RCP) mortality review process of structured judgement review. The trust’s mortality report dated 28 February 2018 reported on mortality across the trust in 2017. Mortality indicators report on mortality at trust level across the National Health Service in England using a standard and transparent methodology. The mortality report recorded that up to November 2017 the rolling 12 month Hospital Standardised Mortality Ratio (HSMR) was 97.15 and the rolling 12 month Summary Hospital-level Mortality Indicator (SHMI) was 100.16 in October 2017.

The trust had outlier status in respect to published mortality ratios. However, the mortality report recorded that for quarter 3 (Q3) the trust’s position demonstrated both the SHMI and HSMR ratios were within the expected ranges. However, the trust continued to show individual diagnosis groups which warranted action as part of the trust’s mortality reduction plan. There was an action plan in place to direct governance processes and address specific mortality diagnosis groups found in need of improvement. For example, people with learning disabilities.

The trust had a monthly safeguarding operational meeting with the clinical commissioning group (CCG) where safeguarding training rates and incidents were discussed and monitored, together with the safeguarding strategy.

Senior managers told us the main risk to services was the trust’s medical model. The senior managers told us the current “on-call” model needed to be “bolstered” due to increased demands on the service. Senior managers also said the trust’s financial position made managing the hospital’s estate “difficult.” The divisional director for acute medicine told us demand and capacity management tended to take precedence over other priorities.

The divisional director for acute medicine told us audits were not one of the division’s strengths. Senior divisional staff said the service were improving, but not at the speed they would like.

Medical and nursing staff we asked, from across all divisions, identified nursing and medical staffing as the main risk to services.
There were sufficient amounts of computer terminals to enable staff in accessing the intranet, worldwide web, and internet.

The deputy chief operating officer (COO) told us there were no concerns in regards to the integrity of the trust’s data. The deputy COO said the trust’s data had been subject to a lot of scrutiny from external agencies and data integrity had not been identified as an issue either internally or externally.

Both the specialist medicines and care of the elderly divisions had dashboards to enable senior staff in monitoring divisional key performance indicators (KPI).

Senior matrons told us the introduction of an electronic early warning system for patients at risk of deterioration had made a significant difference.

**Engagement**

The trust had an annual awards event to recognise individual staff or teams. For example, staff on Erica ward showed us the ‘Winner: most improved patient service’ award they had received in the November 2017 trust awards. Staff told us the awards event was sponsored by the trust charity. A member of staff told us, “It made us feel valued.”

The deputy chief nurse told us the trust had held workshops with staff from around the trust to gain staff ideas for a new trust safeguarding strategy. The director of public health had also attended workshops. The new adults’ and children’s safeguarding strategy was ready and waiting for the trust board to sign it off prior to launch.

The learning disability nurse had a working group, which involved patients and carers to gain the perspective of people who use services on learning disability services across the trust.

The care of the elderly matron had weekly matron’s surgeries where patients or carers could speak with the matron.

Care of the elderly wards were engaging with beauty therapy students from local colleges to offer beauty therapies to patients. The wards were also part of the local dementia society and frailty network.

The trust conducted an annual staff survey. The results were not available for the 2017 staff survey. However, we viewed the results for the specialist medicine staff survey published in January 2017. To the question, “care of patients is my trust’s top priority,” the trust scored 66% positive responses, this was less than the trust average of 73%. To the question, I look forwards to going to work,” specialist medicine division’s responses at 67% positive were better than the trust average of 63%. To the question, “there are enough staff at this organisation for me to do my job properly,” the specialist medicine division positive responses at 31% were the same as the trust average of 31%. There was a comprehensive action plan in response to the staff survey, which outlined actions the division would take to address areas requiring improvements from the staff survey, including increased support for staff. However, the action plan did not address actions the service was taking to recruit new staff.

We did not see the results of the staff survey for acute medicine. However, we viewed an action plan in response to this survey for care of the elderly. This detailed actions the trust were taking in response to the staff survey, including staff receiving training in ‘breakaway’ training, this equips staff with skills in dealing with aggression. Staff we spoke with confirmed they had received ‘breakaway’ training.
Learning, continuous improvement and innovation

The trust had an improvement portfolio. This was a plan of action to meet the objectives of the trust’s quality improvement agenda, including: staff turnover rates, staff retention, and staff appraisal rates. The improvement portfolio was monitored by a trust improvement portfolio board. The board produced a monthly improvement portfolio report, which reviewed the status of the trust’s quality improvement initiatives and whether the timescales and key performance indicators (KPI) were being met. We viewed the February 2018 improvement portfolio board report and saw that where timescales and KPI were not met, a plan of action was in place to address this.

Erica ward was piloting the ‘model ward’ approach. This was an approach to monitoring performance on the by having ‘model ward boards’ whereby ward compliance audits, patient outcomes, key performance indicators and staffing levels were publicly displayed. The aim of the model was to drive improvements and consistency. The ward was expected to complete regular compliance audits of agreed criteria and use the outcomes to benchmark improvements in services over time. Staff told us they had recently introduced the model and the patient experience coordinator had completed the initial benchmarking in November 2017 and January 2018, this had given the ward a baseline to work from.

Learning and development staff said they had to think of creative ways of retaining staff. The trust had introduced nurse apprenticeships, this had enabled health care assistants (HCA) who lived locally and had worked for the trust for some time the opportunity to train as qualified nurses. Learning and development staff said the apprentices were staff who had shown commitment to the trust and lived in the locality, and as a result were more likely to stay with the trust on qualification.
Barking, Havering and Redbridge University Hospital Trust provides surgical treatments over two sites, with a total of 254 inpatient surgical beds. The trust had 37,989 surgical admissions from September 2016 to August 2017. Emergency admissions accounted for 12,610 (33%), 18,477 (49%) were day case, and the remaining 6,902 (18%) were elective.

King George Hospital is one of the two trust hospitals that provides surgical services. It provides a range of elective and emergency surgical services. These include orthopaedic, breast, colorectal and ophthalmic. There are six theatres and one day unit theatre. There are three surgical wards; Iris ward, (urology) Heather ward, (general surgery) and Dahlia ward, (orthopaedics). There is a urology receiving room and a pre assessment unit. There is an adult day unit for ophthalmology, eye cataract surgery and other day surgery activity and a urology diagnostics unit. The hospital has a total of 75 surgical inpatient beds. There is also a discharge lounge.

We spoke with fifteen patients and four relatives. We spoke with 34 members of staff that included surgery ward nurses, healthcare assistants and surgery ward managers. We spoke with theatre and recovery staff including nurses, operating department practitioners, consultants and junior doctors. We spoke with radiographers, anaesthetists, pharmacists, divisional managers and lead nurses.

We visited all areas of the hospital that undertook surgery activity including the surgical wards, theatres, recovery, adult day unit, pre assessment unit and discharge lounge. We reviewed nine drug charts, 12 patient records and checked equipment in all areas we visited.

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 trust was unable to provide information broken down to CQC core service levels or by individual hospital site. Information provided below covers the trust’s ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust.

The trust set a target of 90% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental staff is shown below:
## Infection Prevention and Control - Aseptic Non Touch Technique

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>307</td>
<td>354</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>304</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>293</td>
<td>354</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>290</td>
<td>354</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>285</td>
<td>354</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate (%)</th>
<th>Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Aseptic Non Touch Technique</td>
<td>557</td>
<td>566</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>552</td>
<td>566</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>550</td>
<td>566</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>541</td>
<td>558</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>545</td>
<td>566</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>539</td>
<td>566</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The trust met the training target for all applicable courses for nursing staff in Surgery.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We were provided with more up to date information during the inspection. ‘Best’ (BHRUT education staff training) was a piece of software that recorded appraisals and mandatory training. Best recorded everything that the trust felt was mandatory. This included competency based items that were in addition to standard mandatory training items. For instance dementia awareness, end of life care, mental capacity and smoking cessation advice. In addition to this, each ward carried out further specialty specific competencies that also counted to trust mandatory training statistics. For example, in urology staff were expected to also be trained in urinalysis and pregnancy testing. These were known as compliance rated mandatory training topics.

A weekly trust wide report on compliance rated mandatory training was shared. At the time of our inspection, this showed that the surgery division within the trust had a 90.9% attendance rate against the trust target of 90%. For King George Hospital surgery services, Dahlia ward was at 100%, Iris ward was at 92.59% and Heather ward was at 78.26%. We were told that there had been no matron for two months up to January 2018 for Heather ward. Percentages also accounted for maternity leave and long term sickness.

There was a nominated sepsis lead for surgery who had been in post for two months. They attended monthly meetings, the sepsis steering group and a trust wide meeting where all divisions came together to share knowledge and issues. One priority had been to increase compliance with sepsis training for nursing and medical staff, which had taken place. There was now a key trainer for each surgery ward at the hospital who had tier 1 and tier 2 training in sepsis management. They carried out on the spot training on wards and raised awareness. Staff interviewed on Dahlia ward told us they had been sepsis trained on starting at the trust, plus an annual update online.

**Safeguarding**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental staff is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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>303</td>
<td>354</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>292</td>
<td>354</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

For medical/dental staff within surgery, the trust failed to meet the training target for both applicable safeguarding courses.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>521</td>
<td>534</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>541</td>
<td>566</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>24</td>
<td>32</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

For nursing staff within surgery, the trust met the training target for two of the three applicable safeguarding courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Senior managers within the surgery division told us there was a safeguarding lead within each ward and area, known as a safeguarding ‘champion’. All staff were trained in safeguarding level 2. There was also a trust safeguarding team who they felt were responsive. The surgery division’s quality and safety report included safeguarding reporting. There were four safeguarding referrals last year. The predominant issue for the trust was discharge linking up with community teams responding appropriately.

On Heather ward there was a safeguarding board for information. Ward staff were aware of the trust lead and there was a link nurse on the ward.

On the adult day unit we found that all staff were trained to level 2. Staff told us there were no known safeguarding incidents in last year. Staff were able to explain how to escalate any safeguarding concerns. Staff had a clear understanding of safeguarding process, what constituted a concern and how to escalate this.
In main theatres staff told us they were trained to level 2 for adults and children and had completed on-line training and had received specific training for theatres face to face. Staff were aware of the safeguarding lead within theatres and to escalate concerns to them.

**Cleanliness, infection control and hygiene**

The trust had identified areas for improvement in infection prevention and control (IPC). A newly established IPC team was appointed in 2017 with the purpose of implementing a five year strategy to educate staff across the organisation on principles of IPC including hand hygiene. The team worked with infection control specialist nurses, team leads in the operating theatre department, and link staff in all ward areas to share information and keep colleagues updated on issues and developments. We spoke with link nurses who attended regular meetings, shared information, and were able to offer advice to colleagues.

We interviewed the infection control team leads. The team were based at Queens Hospital and had 10.6 whole time equivalent nurses and 1.6 administrative support, with clinical nurse specialists (CNSs) based at both sites of the trust. We were told that the ‘COPE’ team (the Community Orthopaedic Project of Essex) spotted and recorded infections that occurred after a patient was discharged which was due to the in-patient procedure. We were told that the infection control team did not attend ward rounds and did not have oversight of SSIs and were not able to supply the number of clinically significant wound infections on the surgical wards at KGH in the past year. They were unable to identify trends in infection in the hospital, which were basic issues in infection management. We asked for a summary of their activity and were told they looked at pathology results and worked at ward review and nurse liaison. They attended a variety of meetings and spoke of targets, scrutiny, data analysis and e-prescribing. However, there was not much direct contact, for instance, at ward rounds and multidisciplinary team meetings (MDTs). There was not much interaction with the clinical teams outside of meetings or with doctors leading those teams. We spoke with infection control link nurses on wards who told us that infection control nurses had a daily profile on wards which was mainly surveillance focussed, especially of nurses and doctors hand washing.

Incidents of infection on wards were not recorded in any register. All data was trust wide and not broken down by site. The recording of the number of infections on wards was limited to summaries of MRSA and C.Diff statistics. There were no records for streptococcal infection which caused the most morbidity in wounds. Information provided following our inspection showed there had been less than 1% surgical site infections for the periods January to March 2017, April to June 2017, and October to December 2017. This was below the national average of 1.3%. For the period July to September 2017 there had been two reported surgical site infections which equated to 1.6% which was above the national average.

We observed all staff groups 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). Hand washing and sanitiser facilities and personal protective equipment (PPE) were readily available and clearly signposted in all departments we visited. Hand hygiene sections of the monthly IPC audits suggested gel dispenser were available and good hand hygiene standards were observed in the surgery division.
The IPC team conducted monthly audits of all clinical areas to assess against the measures listed in Essential Steps to Safe Clean Care as listed in Department of Health (2003) Winning ways: Working Together to reduce Healthcare Associated Infections.

We saw side rooms being used for isolation purposes where patients had a known or suspected infection, with doors shut and appropriate signage alerting staff and visitors of the infection prevention and control precautions to take. If staff had any concerns about who or how to isolate patients, there was a clear isolation risk policy for them to follow. Each bed in a bay had disposable curtains used for privacy and dignity. These curtains displayed dates of when they were last changed.

Furniture was clean and in good condition, fully wipe-able and compliant with Health Building Note (HBN) 00-09: Infection Control in the Built Environment.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins in accordance with HTM 07/01 The Safe Management of Healthcare Waste 2013. We saw sharps bins were securely kept and not full. We observed general and clinical waste bins in each bay and also in the corridors of the ward. These bins were not overfilled and were labelled clearly.

The monthly performance report was reviewed in the monthly surgery divisional quality and safety meeting, chaired by the divisional manager for surgery and attended by quality and safety leads, specialty managers, the National Institute for Health and Care Excellence (NICE) and mortality lead and the quality and safety matron. December 2017’s monthly performance report ‘ward scorecard’ recorded ‘year to date’ rates of MRSA and C-diff screening. For MRSA screening, Iris ward reported 94%, Heather ward reported 95% and Dahlia ward 100%.

Compliance with cleaning was ensured by monthly cleaning audits as well as spot check audits. These audits were carried out by the housekeeper supervisor and then shared and discussed with the ward matron. If the audit found below 95%, compliance action plans would be formed and an increase in spot checks undertaken. Cleaning books were kept on wards and were checked daily and covered a range of areas. The wards and kitchens we visited were found to be clean. On Dahlia ward there was a sluice with three commodes which were clean. In the adult day unit we found the environment and equipment to be clean and there was a newly refurbished dirty utility.

Recovery and theatre environments were found to be clean and there were clean stickers on all equipment and we observed good hand hygiene practice. Theatres we visited were clean, tidy, and well organised. In recovery we observed good hygiene. However, the taps in the changing room toilets were hand activated. This presented a potential infection risk.

**Environment and equipment**

In theatres we found that equipment was kept in good order and stored neatly. Theatres were found to be tidy and well organised. All portable electrical testing (PAT) of appliances had taken place and were in date. In the equipment store, items were well organised and labelled. Infusion pumps were tested and in date. Equipment in the corridor was kept within marked ‘parking bays’. Clean labels were in place. The resuscitation trolley in theatres was secured. A sharps bin was in place and the check list demonstrated regular checks. Sharps bins and clinical waste was clearly labelled. The resuscitation trolley was clean, secured and checks were taking place.
We found recovery to be a well-lit, well equipped, spacious and calm atmosphere. Bloods needed for transfusion came from the haematology department in King George and managers were happy with the service. Theatre staff reported the department had all the facilities they needed to do their job.

We observed a procedure on the all-day list of a consultant orthopaedic surgeon. The standard of equipment in theatre was good. The operating theatre was clean, light and spacious, with laminar air flow.

In the adult day unit we found the environment to be well organised. Equipment was PAT tested and in date. The resuscitation trolley check list demonstrated regular monitoring. Fridge temperatures had been recorded and there was a newly refurbished dirty utility.

On the wards, we found a clean and tidy environment. Equipment was kept in good order and stored neatly. This was with the exception of Heather ward where the kitchen area was generally clean but in parts untidy with cleaner’s cupboards unlocked and toilet rolls on top of the bins in the WC. On Dahlia ward there were four bays of between three and five beds, with two side rooms and a physio room. One of the four bedded bays was dedicated to higher dependency patients. There was a day room which contained chairs and a television. It appeared not well used, austere and bare. There was a linen cupboard which was clean and tidy. There was a sepsis kit that addressed the sepsis six requirements. However, it did not have an expiry date. We also found the ECG machine had an in date PAT test. On the BP machine, the PAT test was in date. The oxygen cylinder was also in date. There were no reported problems with top-up of supplies and equipment.

On Dahlia ward the last two months of checks on the resuscitation trolley were reviewed and found complete. Its contents had been checked weekly. The top contained a defibrillator (lifepack), bag valve mask, clock / stopwatch, closed sharps box, separate mobile suction equipment. Laryngoscope (for endoscopy of the larynx) blades were in sterile wraps but McGills were not sterile wrapped, which was reported to the ward. There were sterile cannulation packs. Intravenous fluids and two drugs boxes were found to all be in date with the exception of the adrenaline which had expired in the month prior to our visit which was pointed out to the ward sister.

On Iris ward we found the sluice was clean and tidy. There were two male toilets and two showers, all clean and tidy. Two blood pressure machines and three pumps had been PAT tested and were in date. There was a sepsis six (the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis) box that addressed the sepsis six requirements and was in date. The resuscitation trolley showed all checks completed and all equipment was in place.

Recovery consisted of a 10 bedded unit with a children’s bay. In main theatres staff told us that equipment availability was not an issue, and that no operations were cancelled due to supplies. We were told hospital sterile services were due to be outsourced to Kent, and there was a good top up system plan for February when this happened. The assumed a turnaround time was currently six hours as a minimum standard, which will become 11 hours once outsourced.

Assessing and responding to patient risk
The service had implemented the National Early Warning Score (NEWS) system developed by the Royal College of Physicians for the detection and response to clinical deterioration in adult patients monitoring for of adult patients on wards. In all of the patient records we looked at we saw the early warning scores were completed electronically and used appropriately. A mobile clinical system that monitored and analysed patients’ vital signs provided clinicians with accurate, real time information to provide risk scores and trigger the need for further intervention. We saw this happened throughout our visit and staff confirmed this was normal practice.

Evidence of national early warning score (NEWS) audits were provided. They took place for Dahlia, Iris and Heather wards, which were measured against the following criteria: 1. Is the required frequency of observations clearly defined? 2. Has a full set of observations been recorded in the last 12hrs? 3. Has the NEWS been recorded for the last 12 hours? 4. Was the NEWS calculated correctly? 5. Have the observations been recorded in accordance with the frequency indicated by the NEWS? 6. If NEWS is five or more or is a single score of three, did escalation occur?

Red / amber / green (RAG) ratings were given against scores out of 100. Below 80% was categorised as red and green was 100% only. Mean scores were provided for each ward for each month and showed scores predominantly in the high 90s and 100% being regularly scored. The only exceptions being Dhalia ward scoring 92% in March and 87% in April 2017.

From November 2016 to October 2017, the trust reported four incidents classified as never events for surgery. All related to a foreign object being left inside a patient during surgery, one of which related to King George Hospital which occurred in May 2017.

As a result of the investigations into the never events, a lack of assurance for the counting of swabs, instruments and devices had been identified as a top risk for the surgery division in July 2017. A revised standard operating procedure was introduced, and standardised pre-printed swab boards, in line with the Association for Perioperative Practice (AfPP) recommendations, were introduced. In addition, two new practice educators for the operating theatre department were appointed as part of the recommendations.

In information provided to us prior to our visit, the trust stated that the World Health Organisation (WHO) checklist had been updated in 2016 as a result of learning from incidents and audit action plans. Currently, theatres audited four of five steps to safer surgery (briefing, sign in, time out, sign out). Debrief was not audited formally. Posters were used to promote compliance with the WHO safer surgery steps.

The trust also told us that before July 2017, theatres undertook monthly audits using 100 random samples to identify that they followed four steps of the WHO. Prior to July 2017, the methodology used to audit the WHO was:
• 100 random WHO check lists forms were collected
• The compliance of all the questions were checked against the four steps to safer surgery
• The WHO form is completed correctly
• Team brief: before the start of surgery
• Sign in: before the start of anaesthesia
• Time Out: before the start of surgical intervention
• Sign out: before any member of the team leaves the operating theatre
• Procedure
• Patient’s details: Last name, first name, date of birth, hospital number
In July 2017, a new theatre data system was implemented. This allowed for the WHO form to be conducted electronically in real time and subsequently reports have been circulated daily, weekly and monthly. To support the data system audit process, senior nurses across both sites undertook peer review that included observation of the WHO. Daily results were discussed at theatres’ huddles and sent to all theatre leads. In September 2017, overall audit compliance for the trust was 98.70% and 99.28% for King George Hospital. The trust stated that as compliance had been high, a remedial action plan has not been required.

We witnessed appropriate execution of the WHO checklist. We observed a procedure on the all-day list of a consultant orthopaedic surgeon, and witnessed a well performed WHO check list procedure carried out and participated in by all team members.

Information submitted after our inspection showed spot check audits taking place against WHO checklists. The most recent to be submitted was for November 2017. It showed that of the 10 cases reviewed, all of them had WHO forms completed and documented appropriately; this gave a 100% pass rate. Recommendations were identified as to continue to remind all staff of the importance of the WHO checklist and the correct way to complete it and complete the spot check in one month’s time. Spot checks for May and June 2017, the next most recent, showed the same outcome.

We observed a well performed safety briefing, pre–list in theatre 5, with good staff involvement. There was good analysis performed at the safety huddle, which also considered the next day’s requirements of equipment and staff. There was good firm leadership of the discussion.

On Dahlia ward we found a seven day booklet in use for patients that included a number of risk assessments. It included assessment and monitoring for falls, venous thromboembolism, MUST for malnutrition risk, and Braden for pressure ulcer risk. Staff interviewed on Dahlia ward told us that meetings included assessing and responding to risk through reporting on problems, live issues, and case studies. A mobile clinical system that monitored and analyses patients' vital signs was used to record observations and calculate early warning scores automatically. If using NEWS, above four prompted further action.

On Iris ward we observed the use of a whiteboard to signal the status of patients and to identify any risk factors such as falls, delirium, sight issues, red tray use and discharge dates. An outlier board identified urology patients who were anywhere other than Iris ward within the hospital and were to be reviewed daily. We attended the 10am huddle that updated the multidisciplinary team following a morning ward round. It included occupational therapists, physios and nurses. Admissions were discussed, as were NEWS updates, interventions, antibiotic changes (intravenous to oral), patients for theatre, changes to discharge dates, packages of care and social work assessments.

In theatres the safety brief was scheduled daily for 8.20am start followed by the 8.30 safety huddle. At 10am, issues of running lists were discussed. Staff in recovery and theatres told us that handovers were used to alert staff of potential problems and risk. Staff told us they felt fully informed of what went on.
National Safety Standards for Invasive Procedures (NatSSIPs) were embedded in the organisation. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs) and dedicated LocSSIP checklists were in place for invasive procedures such as endoscopy, catheters, CV lines and tracheostomies. A working group was in place to review and develop future checklists and standards.

Arrangements were in place and staff had good knowledge of what to do in the event of a patient deteriorating. Resuscitation equipment was checked regularly and staff reported regular simulations took place.

In pre assessment, staff described good escalation processes to the consultant and anaesthetist if concerns were identified. There was also a social review of patient need, so that the anaesthetist had a full picture of patient. On the adult day unit we observed cards attached to staff name badges that included key information on duty of candour, infection control, safeguarding, information governance, sepsis six and incidents.

Some systems were in place for patients following their discharge from the surgical service. At discharge, patients were provided the ward telephone number or directed to the 111 service, their GP, or the emergency department if they had concerns out of hours.

### Nurse staffing

The trust reported their staffing numbers for nursing staff as at September 2017 for surgery as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>408.61</td>
<td>361.63</td>
<td>89%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From October 2016 to September 2017, the trust reported a sickness rate for nursing staff of 2.4% in surgery. This met the trust target of 2.8%. Overall sickness rates for all core services at the trust for nursing staff were 2.3%. A breakdown by site of sickness in surgery of nursing staff is below:

- King George Hospital: 2.1%
- Queens Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2016 to September 2017, the trust reported a turnover rate of nursing staff of 1% in surgery. This met the trust target of 13%. Overall turnover rates for all core services at the trust for nursing staff were 1.4%. A breakdown by site of turnover in surgery of nursing staff is below:

- King George Hospital: 1.2%
- Queens Hospital: 1.1%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Senior managers within the surgery division reported that the nursing vacancy rate had been reduced from 21% to 8.5% over the last 18 months up to January 2018. Improvement in both vacancy and turnover rates had been achieved by increasing ward support and nurturing a better supportive culture. Managers told us they had increased the number of B6 nursing staff on wards. This meant there was now a B6 or senior B5 on each shift, which had increased the level of support to staff at ward level. We were told that 18 months ago it felt as though as many were leaving as were being recruited, which was not the case now. In terms of nurturing a better supportive culture to reduce turnover, the appointment of a practice development nurse for surgery was a post not previously in place. This post was now specific to the surgery division whereas it had always been a corporate position and non-specific to specialty or division.

Decisions about staffing levels and skill mix were based on patient acuity and dependency and supported by an evidence based workforce planning tool: NICE Safe Staffing guideline (SG1). Staffing was planned using an electronic rostering system which included alerts for anticipated and unanticipated absences such as study leave, annual leave and sickness. Agency and bank nurse shifts would be booked to cover shifts that could not be covered by permanent staff.

The surgery leadership told us staff duty rosters were issued six weeks in advance, which enabled forward planning where shifts were left unfilled. Bank nurses and doctors were used to fill gaps and where this was not possible, they went to agency. Any agency spend needed was escalated to the lead nurse for approval. The trust tried to use regular agency staff as they were more likely to be familiar with trust and divisional procedures. There were vacancy meetings weekly where any high cost shift went to the meeting and the lead nurse had to demonstrate need. For last minute sickness not covered, verbal approval could be gained. For out of hours cover, the site manager could approve. We were told that they were not in very great need for agency nurses.

A regular frustration within theatres voiced by staff related to staffing shifts to agreed levels. This had been better addressed since the newly appointed band 7 manager had looked after the rota and managed to cover all shifts without using external agency staff. Staff also felt this issue now received good support from leadership.

On the days of inspection we found all shifts on Heather ward were short staffed. The early shift was short of one qualified nurse and one healthcare assistant (HCA). The late shift was short of one HCA. The night shift was short of one RGN. It was reported by ward staff that they had been short staffed for a few days. A failure to acquire agency nurses had impacted on the workload. We observed that staff were very busy. We were told that the next day would be better staffed. The Heather ward manager post had now been filled with a secondment post from within the surgery division of the trust. The ward had been without a ward manager for three months and had been supported by the matron and surgical nursing lead, who had continued this support through daily morning contact with the new ward manager and being available to discuss any problems.

On Dahlia ward, they were currently at full establishment, with two RGNs not currently at work; one nurse was on secondment and one on maternity leave and one HCA had just started. There was little use of agency nurses found. Staff we spoke with told us there was little use of agency and they were able to get own staff to cover shortages through use of bank staff. There was no formal induction for agency staff but staff were aware of the need to support agency staff.

Iris ward was fully staffed on the day of this unannounced inspection. However, there were five nursing vacancies out to advert and it was reported there had been a recent increase in budget
due to increased throughput of patients. There was an induction checklist for nursing bank staff and it was reported that their own staff filled most bank shifts. There were no HCA vacancies. Two HCAs were doing nursing associate training, and were currently on placement here for 18 months. A new role of housekeeper appointed to, converted from HCA post.

The adult day unit was under the management of the lead theatre nurse. The senior sister was newly appointed. Staff told us they did not consider sickness rates to be high. There were two vacancies: a band 6 and band 5 which were both due to interview. Staff told us there was no agency usage as in-house bank use sufficed.

**Medical staffing**

The trust reported their staffing numbers for medical staff as at September 2017 for medicine as below. Information provided by the trust was not broken down to site level.

<table>
<thead>
<tr>
<th>Planned staff (WTE)</th>
<th>Actual staff (WTE)</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>225.86</td>
<td>189.27</td>
<td>84%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The trust reported total locum shifts for surgery between 1 October 2016 and 30 September 2017 as 868 locum consultant sessions, middle grade 989 sessions, and 934 for doctors in training. In the for surgery division, one key priority going forward was identified as ‘increased focus on doctor cover and agency costs’.

From October 2016 to September 2017, the trust reported a turnover rate in surgery of medical staff as 0.3% for King George Hospital.

From October 2016 to September 2017, the trust reported a sickness rate of 2% in surgical care for medical staff. This met the trust’s target of 2.8%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust reported that within surgery, between October 2016 and September 2017, 91.7% of shifts that went out to bank and locum were filled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

From August 2017 to August 2017, 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 whole time equivalent staff working at Barking, Havering and Redbridge University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Consultant</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Senior managers within the surgery division told us that while they were not in very great need for agency nurses, they were more so for medical staff. It was reported by ward staff that Dahlia ward had poor medical cover after 8pm. We were told that concerns had been escalated regarding patients returning late from major surgery. There was a shortage of orthopaedic doctors, a shortage of first year doctors (FY1s) and at times the ward had no doctor at all. This had been escalated but it continued to be the case that at times patients were returned late from theatre with no medical presence or support on the ward. Urology covered the ward at night time. There was a majors and large list for breast surgery on Fridays which placed more emphasis on the need for medical cover on evenings and weekends. Staff felt there should be another doctor around at weekends to meet the need of the ward. This was on the risk register but it had not been possible to recruit to post.

Iris ward reported a lack of urology medical staff. There was a designated registrar on weekdays who supervised junior doctors and ward rounds. However, a lack of access to medical staff at weekends was reported. Staff interviewed on both Dahlia and Iris wards reported that lack of access to medical staff at weekends and delays in discharge as a result.

Health Education England withdrew first year trainee doctors from the trust in November 2016 due to quality of training. However, they returned them in April 2017 following the introduction of an improved educational programme that was put in to place to support them.

**Records**

A combination of paper and electronic patient records was in place. Arrangements for the management of patient records were set out in trust policies. Compliance with the policies should be audited on a monthly basis. We saw this happened and that overall compliance with records standards from January 2017 to December 2017 ranged between 90% and 100% in all areas within the surgical division.

Trust policies stated that all records which included patient-identifiable information must be stored securely and kept strictly confidential within the establishment. We saw this to be the case and saw senior nurses remind doctors to follow this procedure before leaving clinical areas.

We reviewed 12 sets of notes and found that all had been appropriately signed and dated. Venous thromboembolism risk assessments had been completed in 10 of 12 sets of notes. There was evidence that daily ward round review had been recorded in all notes, where applicable. All consent forms had been signed. Assessment of pressure areas had taken place in 11 of 12, and assessment of nutritional status had taken place in all where applicable. There was evidence of MDT input in all where applicable and there was evidence of input from the pain care team in all where applicable.
Medicines

Medicines were stored appropriately and securely. Staff had positive relationships with the trust pharmacy staff and could obtain medicines quickly when required, seven days a week. The process of making sure patients were discharged with the correct medicines was robust. However, we did see an example where people had not received their medicines as prescribed during their hospital stay including medicines for blood pressure and heart failure. There was no opportunity for patients to maintain independence and self-administer their own medicines.

Controlled drugs were stored securely and checked regularly in line with policy, and were disposed of appropriately. Emergency drugs were available including oxygen, and were safely stored and checked regularly. All were found to be in date. Venous thromboembolism assessments had been completed. FP10s were available, had been used appropriately and were securely managed.

Fridge temperatures were being monitored daily. Room temperature monitoring highlighted treatment rooms were consistently above 25°C. This was pointed out to the trust pharmacy team who reduced the expiry on and removed certain medicines in response. Appropriate systems of storage and disposal were in place for the use of Mitomycin (cytotoxic). However, there was not always a date of opening on liquid medicines such as oxycodone liquid and morphine sulfate solution.

Medicines prescribed in line with policy and allergies were recorded on all charts we reviewed. Staff had access to current British National Formulary both in hard copy and online. There was also an online system for giving injectable medicines. The critical medicines list was readily available in the pharmacy communication book and there was a flow chart for how to obtain them. Hypo boxes were available for treating low blood sugar levels promptly.

Pharmacy staff were available on surgical wards every weekday, to complete medicines reconciliation, check discharge letters and supply medicines. Patients were not given the opportunity to self-administer when appropriate.

Medicine reconciliation was taking place and being appropriately recorded on the drug chart. A transcribing technician assisted doctors fill in the discharge summaries with medicines to speed up the discharge process. However, no blister packs or similar compliance aids were supplied at discharge even for patients already established on them.

The prescribing of antibiotics was appropriate and in line with the trust’s policy. Prompts were embedded into drug charts to ensure appropriate review.

Feedback on learning from medicines related incidents was given at ward meetings by pharmacy staff. Ward staff we spoke with told us they had a good relationship with the trust pharmacy team and on-call service, who they described as approachable and helpful. There was access to an emergency drug cupboard and a pharmacist on-call team were available out of hours. A pharmacy bulletin was regularly produced that highlighted any safety issues and supply problems with medicines.

Pharmacy staff were checking the discharge letters for accuracy before discharge and medicines ready for patients to take away were available on wards for common medicines to facilitate discharge.
In recovery we observed properly locked and organised controlled drugs management. The non-controlled drugs cupboard was left unlocked throughout the day but was supervised by the presence of someone at the desk.

**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 November 2016 to October 2017, the trust reported four incidents classified as never events for surgery. All related to a foreign object being left inside a patient during surgery, one of which related to King George Hospital which occurred in May 2017.

In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2016 to November 2017. This table lists the types of incident in each location and a total.

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Queen’s Hospital</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maternity/Obstetric incident meeting SI criteria: mother only</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Senior managers within the surgery division told us that incident reporting had improved over the last 18 months and reporting incidents was encouraged. This included reporting incidents of near misses and no harm. The positive reporting culture meant 70% of reported incidents were no harm and near misses. All reported incidents went to the surgery division’s lead nurse and quality and safety team. Incidents were reported on in monthly performance reports for the surgery division and for the anaesthetics division who had responsibility for theatres, and were reviewed at their divisional quality and safety meetings.

If an incident reporting form (IR1) was raised and applied to patient care, a ‘round table’ meeting was held and attended by relevant ward managers and lead matrons. This was to gain an understanding of what had happened and decide on shared learning regarding practice. We were
told that actions could include shadowing a member of staff or completion of an audit. We were
given an example of an incident in December 2017 from a surgical ward. Action and learning from
this incident included getting input from the nutritional nurse to discuss practice on the ward.
Agency nurses were not competency trained by the trust so a second action was that trust nurses
will look after the right patients with regard to the skill mix required.

All staff we spoke with told us they felt confident to report incidents and were encouraged to be
open and honest. They felt they had a good understanding of what and how to report. During our
visit we observed examples of incidents reported and escalated by staff from a range of disciplines
who worked at different levels across the service. We saw that incidents were openly discussed by
staff with patients and their relatives where applicable. Staff provided examples of where they
received written and verbal feedback from incidents raised and felt this was informative.

In theatres and recovery, all staff were trained to record incidents which were managed by the
team and fed back through meetings and emails. With regard to recent Never Events, staff told us
they made everyone more aware and pay attention. It became a learning opportunity for the
service and people had become more careful. Staff felt this had been well managed by theatre
leads at King George Hospital. Training and reporting had increased the number of incidents
reported and staff felt there was a good reporting culture. Feedback was emailed to individuals,
round table events took place immediately afterwards and all incidents were discussed at
governance meetings with action plans. There were now two dedicated education posts at band 7,
and staff had a clear understanding of learning from never events.

On Iris ward the safety dashboard was on display for staff. The noticeboard described the last
three IR1s with lessons learned and consequences to patient harm or no harm. On Heather ward
the safety dashboard showed 161 incidents which were mostly falls but no harm and two inherited
pressure ulcers. In theatres, Never Events were detailed on noticeboards along with learning
outcomes.

Staff we spoke with on Dahlia ward told us they were encouraged to report incidents via IR1
reporting forms. We were told that IR1s were completed for cancelled operations and that staff
received feedback on reported incidents from senior staff individually and at ward meetings. Staff
we spoke with were aware of trust never events.

Staff were aware of when to escalate a patient issue to an IR1, when to involve PALS, pharmacy,
the matron and nurse in charge as appropriate.

Duty of candour
Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open
and transparent with a patient when things go wrong in relation to their care and the patient suffers
harm or could suffer harm which falls into defined thresholds. The service had a system in place to
ensure that patients were informed when something went wrong, given an apology and informed
of any actions taken as a result. Staff we spoke with from all levels of the organisation showed an
understanding of duty of candour, when they would use it, and the actions they would take. Staff
were introduced to this during their induction programme as part of their corporate essential
learning.
Staff we spoke with on Dahlia ward were clear on the Duty of Candour and on providing support and apology to patients.

Surgical Site Surveillance
It is a mandatory requirement to participate in the Nosocomial Infection National Surveillance Scheme (NINSS) study of Surgical Site Infection (SSI). Nationally all trusts are expected to provide a minimum of three months orthopaedic surveillance data of one of the orthopaedic options:

- Total Hip Replacements (THR)
- Total Knee Replacements (TKR)
- Repair of Neck of Femur

In information provided to us prior to our visit, the trust stated they had participated in SSI surveillance for the past 12 months, with a rolling programme for fractured neck of femur and a month rotational programme for total hip replacement and total knee replacement. The data was collated by the Community Orthopaedic Project of Essex (COPE team) nurse for total hip and knee replacements. This data was uploaded to the public health England website. The data was provided to the infection control team via the Divisional reporting system.

The percentage of SSI’s found from the audits is detailed below for the last 12 months (excluding July-Sept-data currently being collated)
Fractured neck of femur:
Oct-Dec 2016- 0.6%
Jan-March 2017- 0%
April –June 2017- 0.8%

This data showed low incidence of infection therefore no remedial actions were required.

Elective knee:
Oct-Dec 2016- TKR- 0%
Jan-March 2017- THR- 1.4%
April-June 2017- TKR- 1.3%

This data showed a rise in the number of SSI’s in elective knee, however following investigation, no concerns or themes were raised to generate any conclusions or recommendations for improvement. This continued to be monitored through the trust infection, prevention control meeting.

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 suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported 10 new pressure ulcers, 47 falls with harm and no new catheter urinary tract infections from November 2016 to November 2017 for surgery.

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

![Graph of Total Pressure Ulcers (10)]

![Graph of Total Falls (47)]

![Graph of Total CUTIs (0)]

(Source: NHS Digital)

Senior managers within the surgery division told us that a monthly performance report was produced in relation to harm free care and included safety thermometer data audits. The monthly performance report recorded rates of hospital acquired pressure ulcers, falls, falls resulting in severe harm, VTE assessments and dementia screening. The ward scorecard contributed to monthly performance report, which was reviewed in the monthly surgery divisional quality and safety meeting, chaired by the divisional manager for surgery and attended by quality and safety leads, specialty managers, the NICE and mortality lead and the quality and safety matron. December 2017’s monthly performance report showed that ‘year to date’ the patient safety thermometer harm free care scores for each surgical ward at King George Hospital. Dahlia ward had provided 100% harm free care, Iris ward 97.26% and Heather ward 98.84%.

On the surgery wards and the adult day unit there were displays of safety and performance information for patients, visitors and staff. Staff told us safety thermometer data was collected every Thursday.

Major incident awareness and training
A major incident plan was available on the staff intranet, and associated action cards were accessible to relevant staff. This plan provided clinical guidance and support to staff on treating patients in the event of different kinds of emergency incident.

Since November 2017 the trust had called a major internal incident five times because of the volume of patients and lack of beds.

There was a business continuity policy for recovery from disruptions to critical services such as an external incident, fuel shortage, severe weather or facility damage at a hospital site. Restoration of emergency services was the highest priority. All staff were aware of this.

**Is the service effective?**

**Evidence-based care and treatment**

We spoke with the quality and safety lead nurse for surgery, whose main role was leading on evidence based practice. They took over responsibility for disseminating NICE guidance in June 2017 from the compliance team. Guidance was published on the last Wednesday of each month, and every first Wednesday of each month the trust’s NICE compliance group met where published guidelines were reviewed. Members of the group included the lead consultants and quality and safety leads. Guidance assessment tools were then sent out to consultants who supplied evidence that supported new guidance.

Different aspects of guidance were broken down by division and confirmation was expected that new guidelines had been disseminated. Action logs of previous meetings and monthly reports were reviewed at the meeting and at divisional level. The quality and safety lead nurse for surgery met with the divisional leads and explained guidance in order to comply with NICE. Guidance was then disseminated by divisional leads.

Revised NICE guidelines were discussed in the divisional quality and safety meetings with evidence to support compliance. The quality and safety lead nurse for surgery took over responsibility for disseminating NICE guidance in June 2017 from the trust wide compliance team. Within the surgery division, one consultant was allocated to be the lead for NICE. Previously, compliance with NICE guidance was adjudged to be at 39%. This was due to lack of evidence. However, this had risen to 71% in September and in December 2017, had reached a 95% compliance rate.

Email confirmation that specialties and divisions were compliant with guidance was accepted. However, compliance was not being audited. We were told that some areas of compliance were registered with the audits team but it was not clear which these were or when they had been audited. Plans to amalgamate audits of guidance and compliance were in discussion. However, there was no oversight of audits and no real assurance. We understood that no team had responsibility for delivering audits of this. However, information on progress with compliance was shared with the CCG, reported to CQRM and included in divisional performance.

**Nutrition and hydration**

Staff used national guidance tools to assess patients’ hydration and nutrition needs that were set out in an up to date BHRUT nutrition and hydration policy. The trust collected data to inform compliance with food standards. These standards included screening of patients at risk of
malnutrition using a national malnutrition universal screening tool (MUST). The MUST score was completed within 24 hours of admission, and then weekly or more frequently if necessary. If the assessed score was greater than two, nurses referred the patient to the dietitians for a review. In all of the patient records we looked at we found these were completed by staff.

On surgery wards we found a seven day assessment and monitoring booklet in use that included a number of risk assessments including MUST for malnutrition risk, and Braden for pressure ulcer risk. We reviewed 12 sets of notes and found that assessment of pressure areas had taken place in 11 of 12, and assessment of nutritional status had taken place in all where applicable.

A nutrition notice board was displayed on each ward to indicate special dietary requirements and highlight nutritionally at risk patients. Staff had access to snack trolleys which they offered to patients in between mealtimes. This helped to support patients’ nutritional intake and hydration. In the discharge lounge we saw staff offered patients hot or cold drinks and snacks after their surgery. Staff were able to access meals and refreshments for patients’ different dietary requirements based on personal preference or cultural needs. Patients were referred to dietitians and speech and language therapists for assessment of safe swallow reflex if required. Wards had link nurses for nutrition who attended regular meetings, shared information, and were able to offer advice to colleagues.

**Pain relief**

There was a trust wide pain management team consisting of six specialist nurses and a team leader who worked seven days a week across both acute sites within the trust. The practice development lead for surgery had been scoping competence within the surgery division and developing competency documents in a number of areas including for pain management. In partnership with the pain team, competence had been scoped and a comprehensive pain passport was being developed for use.

Work had been completed within the surgery division for nurses and HCAs working to be able to look after a patient with an epidural. There was now a level 1 foundation e-learning in pain management for HCAs and level 2 e-learning and face to face learning on the ward for all HCAs and nurses. Level 3 consisted of two e-learning modules. There was also a face to face training session on theory and practice for all surgery wards’ band 6 and band 7 nurses, and anyone who was likely to act up in charge. At the time of our inspection, five level 3 sessions had taken place across both acute sites and all eligible nursing staff had completed this training. To complete the training, each nurse conducted three full pain assessments with a pain team nurse specialist and completed a final written test. Once passed they were deemed to be able to look after a patient with an epidural.

Patients we spoke with told us their experiences of pain management. Patients told us their pain was being well managed. On arrival for planned surgery we were told pain was checked. Post surgery patients told us that ward staff asked them regarding their pain levels. Patients described staff as responsive to call bells for assistance with pain management. One patient told us “the staff were extremely busy and very kind to me. I can’t fault them. The night staff were excellent. I was in pain. They went above and beyond. They got tablets for my pain and got me a paracetamol drip”. One patient who had major surgery five days prior to the inspection reported a good response to the call bell and felt pain was managed well with analgesics and in good time. Another patient reported they had an epidural that they thought was effective and well managed.
We reviewed 12 sets of notes and found there was evidence of input from the pain care team in all where applicable.

**Patient outcomes**

From August 2016 to July 2017, patients at King George Hospital had a higher than expected risk of readmission for elective admissions than the average for England. In terms of the most common specialties for elective admissions, urology patients at King George Hospital had a higher expected risk of readmission, whereas Trauma & Orthopaedics and General Surgery patients at King George Hospital had a similar risk of readmission to the average for England.

![Elective Admissions - King George Hospital](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*  

Overall, patients at King George Hospital had a lower than expected risk of readmission for non-elective admissions than the average for England. In terms of the most common specialties for non-elective admissions, performance was mixed. Urology patients at King George Hospital had a higher expected risk of readmission for non-elective admissions than the average for England. General surgery and Trauma & Orthopaedics patients at King George Hospital had a lower expected risk of readmission for non-elective admissions than the average for England.

![Non-Elective Admissions - King George Hospital](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top*
In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 5.8% which was within the expected range. The 2016 figure was 5.9%.

The proportion of patients having surgery on the day of or day after admission was 61.6%, which was worse than the national standard of 85%. The 2015 figure was 58.1%.

The perioperative medical assessment rate was 82.4%, which met the national standard of 100%. The 2016 figure was 86.8%.

The proportion of patients not developing pressure ulcers was 99.1%, which falls in the top 25% of trusts. The 2016 figure was 96.7%.

The length of stay was 23.8 days, which falls in the middle 50% of trusts. The 2016 figure was 25.6 days.

(Source: National Hip Fracture Database 2016)

In the 2016 Bowel Cancer Audit, 74.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This figure referred to services given in the year ending March 2015. This was higher than the national aggregate. The 2014 figure was 75.6%.

The risk-adjusted 90-day post-operative mortality rate was 3.6% which was similar to the national aggregate. The 2014 figure was 0.9%.

The risk-adjusted 2-year post-operative mortality rate was 26.3% which was within the expected range. This figure refers to services given in the ending March 2013.

The risk-adjusted 30-day unplanned readmission rate was 10.5%. No figure was provided for the previous year.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 48.8% which was within the expected range. The 2013 figure was 55.4%. Though this information came from one audit there are multiple years of service to which it refers.

(Source: National Bowel Cancer Audit)

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.9% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2016 figure was 1.8%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 27 days, which was worse than audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was within the expected range at 4.9%. The 2015 figure was 3.9%.
In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 26.5%. This was higher than the national aggregate of 13.7% and was above the threshold in the audit of 20%.

In the 2016 National Emergency Laparotomy Audit (NELA), the King George Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 101 cases.

The King George Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 85 cases.

The King George Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 45 cases.

The King George Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 25 cases.

The risk-adjusted 30-day mortality for the King George Hospital was within expectations, based on 101 cases.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 performance on groin hernias was similar to the England average for the EQ VAS score however EQ-5D index score was worse than the average for England.

For Varicose Veins, performance was mixed across the three indicators in comparison to the England average.

For hip replacements, performance was about the same as the England average. For Knee replacements was about the same as the England average.

(Source: NHS Digital)

Competent staff

Due to the way data is held on their local systems, the trust was unable to provide appraisals information broken down to CQC core service or by individual hospital site. Information provided below covers the trust’s ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust.

From April 2017 to October 2017, 84% of staff within surgery at the trust had received an appraisal compared to a trust target of 85%. A breakdown of appraisal rates by staff group is below.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Number of individuals trained - Apr 17 to Oct 17</th>
<th>Sum of Number of individuals required - Apr 17 to Oct 17</th>
<th>Appraisal Rate (%)</th>
<th>Average of Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Scientists</td>
<td>8</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>46</td>
<td>50</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>519</td>
<td>566</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>5</td>
<td>6</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>170</td>
<td>196</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>129</td>
<td>156</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>877</td>
<td>984</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
There had been a dedicated practice development nurse for the surgery division in post since November 2017. Previously, practice development had been under the management of a trust wide corporate team. Work had recently been carried out to assess the division’s practice development priorities that involved scoping competence and developing competency documents. There had also been shadowing staff for performance and development.

Work had been carried out to scope compliance with training and competence among surgery staff. This included ward based competence for specialties within surgery. This had been underway with Heather ward but was yet to move on to Dahlia and Iris wards. Work was currently underway on working with blood transfusion patients. The practice development nurse was reporting back on scoping. As part of this work, in early December 2017, they placed pain competence around nursing patients with epidurals on to the risk register. There was now a higher level of competence and it was felt that this could be removed from the risk register. We were told this had been prioritised because it had been supported by the leadership within surgery and staff had been released at short notice to attend the training.

Another piece of work taken on by practice development for surgery, was around mentorship and preceptorship and the development of competency frameworks within the specialisms. In the eye unit a meeting had been set up with the lead nurse to agree competencies which were currently in draft. These would be taken to the steering group within surgery, ratified and rolled out.

On Dahlia ward student nurses of which there were five, were being supported. However, we were told that it was problematic finding mentors. The trust had a mentorship course. One student nurse felt slightly pressured by their mentor who expressed frustration at perceived inability to learn quickly. Other ward staff told us they felt the trust was supportive of staff development.

The bank and agency staff we spoke with on the wards told us they felt well supported and had received induction to work here. They had completed mandatory training, one through in house bank and the other via their agency.

Recovery staff were trained in the predictive model of recovery but only BLS trained (not ILS or ALS). All staff but two had basic life support (BLS) resuscitation qualifications. The manager and one other had an intermediate life support (ILS) resuscitation qualification. Recovery staff stated that further training would be beneficial to the unit.

In information submitted prior to our inspection, from April 2017 to October 2017, records showed that 85% of nursing and midwifery staff had completed resuscitation level 2 - Basic Life Support – Adult. From April 2017 to October 2017, 64.5% of medical and dental staff had completed resuscitation level 2 - Basic Life Support – Adult. In addition, from August 2016 to July 2017 adult basic life support (level 2) training compliance rates ranged from 79% to 83% which was below the trust target of 90%. No data was available in relation to intermediate or advanced life support training.

Records we requested after our inspection confirmed that band 5 nurses and 95% of band 6 nurses had had intermediate life support (ILS) training. We saw there were monthly training dates and all would have Advanced Life Support (ALS) training by May 2018. This followed a significant training effort in this area in 2017.
There was a new lead nurse in theatres and staff felt there were renewed opportunities for staff development which leadership were supporting. This included opportunities for leadership training and root cause analysis and risk management. However, for HCAs there was no available career progression to a band 3 or band 4 despite hard work and knowledge from experience.

On the adult day unit, new and student nurse staff told us they had received induction on the unit and that there were learning opportunities that included in admitting/discharging patients, knowledge in urology and eyes and competence in catheterising. Staff were happy with the preceptorship programme which was meeting their needs but it was felt that more manual handling training was required in addition to the mandatory training, specifically with hoists. The unit had to borrow hoists as required because they were not frequently needed, so staff were not as familiar with how the equipment worked as they could be.

**Multidisciplinary working**

There was an effective multidisciplinary team (MDT) working environment and multidisciplinary input on the wards. On Iris ward we attended the 10am huddle that updated the multidisciplinary team following a morning ward round. It included occupational therapists, physiotherapists, nurses and HCAs. On Dahlia ward we observed the daily MDT handover with nurses, therapy staff and medical staff.

There was also a follow up community service for orthopaedic care that included nurses and physios. They were on call at weekends and had daily contact with the ward during the week. For Havering patients there was occupational therapy facilitated re-enablement care to implement care packages.

Ward staff we spoke with told us they had a good relationship with the trust pharmacy team and on-call service, who they described as approachable and helpful. Patient records demonstrated multidisciplinary input as well as nursing and medical teams. We reviewed 12 sets of notes and MDT input from physiotherapy, dietitians, occupational therapists, pharmacists and pain care team.

We observed the weekly colorectal multidisciplinary team meeting between King George and Queens hospital, which was via video link. A histopathologist and radiologist were in attendance together with the surgeons. There was good discussion of cases and a good attendance at both meetings (18). The meeting brought out some waiting list problems. For example, for one significant cancer case, the surgeon of first choice could not offer an operation date until the 3 March (5-6 weeks on).

**Seven-day services**

Staff reported a lack of access to medical staff at weekends. This was on the risk register but the trust had been unable to recruit to posts. This impacted on patient care and could lead to delays to discharge. There were major surgery lists on Fridays and we were told by staff there was not sufficient medical cover to meet the needs of the wards at weekends. This impacted in particular on Dahlia ward.

Two physiotherapists covered weekends. However, occupational therapy, dietetic, and speech and language therapy services were provided from Monday to Friday only with no service at weekends. This meant that rehabilitation of patients was not maximised.
Trauma lists ran at weekends. Senior managers within the surgery division told us that some elective procedures also took place at weekends with beds freed up for this.

Diagnostic imaging was available from 7.30am to 8pm with access available until midnight. If imaging was not urgently needed, arrangements were made for patients to be seen early the next day.

There was a trust wide pain management team consisting of six specialist nurses and a team leader who worked seven days a week across both acute sites within the trust. There was an on-call pharmacy team service at weekends, who ward staff described as approachable and helpful. There was also access to an emergency drug cupboard out of hours.

The adult day unit sometimes had Saturday and Sunday operating lists, so the unit’s ward was opened. Nurses were offered these shifts as a bank shift. However, HCAs were required to work this as part of their rota. This could sometimes lead to bank nurses working who were not familiar with the ward so healthcare assistants had to show them what to do, this led to poor morale and caused delays in meeting individual needs such as pain relief. With only one trained nurse on duty, staff had to sometimes go to another department to get a signature for TTA’s causing further delay and issues around who was supervising the unit.

Health promotion

Staff supported patients, and their relatives where appropriate, to manage their own health and wellbeing, and to maximise their independence following surgery. We saw enhanced recovery programmes that enabled patients to be actively involved in the recovery phase following surgery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation.

Patient records we looked at showed that staff in the surgical pre-assessment unit discussed eating well, exercise, relaxation, smoking cessation, and alcohol consumption and the importance of trying not to worry too much about the surgery. People who were smokers were referred to the smoking cessation services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty (MCA/DOLS) training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Due to the way data are held on their local systems, the trust was unable to provide information broken down to CQC core service or by individual hospital site. Information provided below covers the trusts ‘Surgery’ and ‘Anaesthetics’ directorates across the whole trust.

The trust set a target of 90% for completion of MCA/DOLS training. A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty courses from April 2017 to October 2017 for nursing staff is shown below:
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>61</td>
<td>157</td>
<td>39%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>143</td>
<td>363</td>
<td>39%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We were provided with more up to date information during the inspection that showed work had taken place to improve on mandatory and other training attendance figures. A weekly trust wide report on compliance rated mandatory training was shared. At the time of our inspection, this showed that the surgery division within the trust had a 90.9% attendance rate against the trust target of 90%.

Senior managers within the surgery division told us that if staff did not feel a patient had capacity at any stage, such as when on the wards, during the pre-assessment process or during consent, a full assessment took place.

Staff on pre assessment, surgery wards and in theatres were aware of the need to understand patients’ capacity. For instance, on Heather ward we found that capacity and the Mental Capacity Act were highlighted to staff and there was guidance contained on the safeguarding board for information. There were link nurses on the wards and staff were aware there was a trust lead. However, when we visited pre assessment we learned that consent was being taken on the day of surgery, with many consents still signed on day of surgery for both day cases and major (inpatient) surgery, which could impact on both the patient and theatre schedules if the patient was assessed as lacking capacity.

There was a Deprivation of Liberty Safeguards nurse within the safeguarding team and staff told us they felt supported by this. We were told that a Deprivation of Liberty Safeguard could be put in to place where one to one care was given for support and safety. For instance, to prevent a fragile patient with fractures from unaided walking, for the purpose of preventing further injury.

On the adult day unit, staff had an understanding of MCA and DoLS and had not encountered problems when obtaining consent or capacity. Staff were clear about their responsibilities and doctors’ responsibility. Staff told us that on the adult day unit at 7am the patients arrived and were checked in. Before this they had been seen in pre assessment and given information about the operation, but did not sign a consent form until the day of the operation.

Is the service caring?

Compassionate care
The Friends and Family Test was reported and reviewed in the monthly performance report. The results for the surgery division were broken down by ward. In September 2017, ‘year to date’
scores for Dahlia Heather and Iris wards response rates were recorded as 75%, 57%, 56% respectively. Likely to recommend was reported as 91%, 90% and 90% respectively.

We spoke with fifteen patients in total. With regard to compassionate care, we received positive feedback from everyone. Overall patients told us that staff had been kind, worked very hard and that they felt well cared for. Comments included “brilliant, can't fault it at all. They've been helpful, friendly and polite”. With regard to theatres, one patient told us “everyone of the staff have been kind. They work very hard”.

On the adult day unit patients told us that staff were calming and welcoming. We were told they would recommend to family and friends.

Emotional support

Patients told us that medical and ward staff were emotionally supportive. We were told that staff understood the emotional sensitivity of patients awaiting and having just undergone surgery, and that staff were on hand to answer questions and were patient with people.

One patient told us “It’s been good as far as it can be having just had surgery. The aftercare has been supportive. You’ve got a name to go to – you are allocated a breast specialist by name so you have that link”. Another patient told us “the breast screening unit told me I can get in touch any time”.

There was no dedicated counselling or psychology service available for surgery patients.
There was a bereavement service information leaflet available for family and friends in the event of a patient death. This included information on how to access the trust bereavement team and how to register the death. The leaflet also provided information on a range of support services for people to access if needed.

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

We spoke with fifteen patients and five relatives. We were unanimously told that pre assessment staff, nurses, HCAs, surgeons and anaesthetists had all taken the time to explain treatment to them. Staff explained what they were going to do beforehand.

Patient comments included: “my daughter felt included. My husband is my carer. He was made to feel welcome too”; “if mum asks anyone anything they will always try to answer. If they don’t know the answer they will go off and find out the answer”, “the anaesthetist explained what was happening and what she was doing. I can’t complain about anything”.

**Is the service responsive?**

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

Surgery services at King George Hospital had been established to meet the needs of local people. Emergency theatres were available 24 hours a day.

For elective surgery, appointments were booked via a central booking system that would contact the patient with a proposed date, patients then had the option to accept this date or request another. Staff reported where possible they would factor in the needs of the patient.

At pre-assessment, information packs were given to patients that included information on venous thromboembolism, anaesthetic, MRSA and fasting instructions. Patients we spoke with on surgery wards told us they were given useful information regarding their treatment, what was available and what to expect. Packs also contained telephone numbers for further advice.

One patient told us their partner was also their carer 24 hours a day and that they had stayed with the patient overnight, and were not restricted from doing so. We were also told they had been given breakfast and tea. Their carer, who was an elderly man, had slept in the chair next to the bed. When we enquired with staff, we were told there were no makeshift beds available.

Another patient explained to us that there had been a delay in their surgery which meant they had arrived at 10am but did not come out of surgery until 10pm. They were advised that they needed to have someone with them. This had meant their daughter had to pay for over twelve hours parking charge due to the delay. Another patient explained to us that there were some disabled parking bays near to the hospital entrance which were free, but when they were full you had to use the disabled bays in the car park, for which the full parking rate was payable, despite being a blue badge holder. We spoke to a ward nurse who verified there was no concessions for parking within surgery.

The adult day unit worked to a two week turnaround from referral to appointment. Patients saw the doctor they were expected to see and there was clear information, a clear plan with a date for pre–assessment. However, patients told us that they had issues with the flexibility of dates. There
were no concerns about care but all patients had arrived at the same time. Staff told us that at 7am the patients arrived and patients were admitted. Before this they had been seen in pre-assessment and given information about the operation.

A nice feature in theatres was the placement of seats at various points for staff or visitors to temporarily rest or discuss matters.

**Meeting people’s individual needs**

There were numerous assessment processes in place that supported meeting people’s individual needs. There was good evidence of risk assessments and acting on identified risks. This included the identification of sepsis for which staff had received training.

We found whiteboards in use to signal the status of patients and to identify any individual needs such as risk of falls, sight issues, red tray use, (used as a visible indicator of vulnerable patients who needed help and support eating and drinking) and discharge dates.

We attended a 10am huddle that updated the multidisciplinary team following a morning ward round where ongoing patient need was discussed such as interventions, antibiotic changes (intravenous to oral), patients for theatre, changes to discharge dates, packages of care and social work assessments. In pre-assessment, there was also a social review of patient need, so that the anaesthetist has full picture of patient. An assessment booklet included assessment and monitoring for falls, venous thromboembolism, MUST for malnutrition and Braden for pressure ulcer care. Staff meetings included assessment issues, live issues, and case studies. A clinical system was in use (vitalpacs) that monitored and analysed patients’ vital signs and calculate early warning scores automatically.

We found many individual examples where patient need was being met. On Dahlia ward there was a follow up community service for orthopaedic care that included nurses and physios. They were on call at weekends and had daily contact with the ward during the week. For Havering patients there was occupational therapy facilitated re-enablement care to implement care packages.

On the adult day unit, we found that patients’ requiring social care were highlighted at pre-assessment. On Iris ward, a daily ward round by the nurse in charge reviewed all patient charts to identify issues or omissions.

Patients were referred to phlebotomy service, which was co-located in the hospital, if bloods required.

Advice was available from the trust’s learning disability nurse specialist who had a 24 hour target to review referred patients. Senior managers within the surgery division told us they were confident in the service and that staff were able to identify patients who may fit this profile.

Dementia friendly work had been undertaken that included decoration of wards and colour coding. However, not on Dahlia ward. We were told by senior managers within the surgery division that it was very rare to have dementia patients due to the purpose of the ward.

Senior managers within the surgery division told us the hospital served higher than average Asian and eastern European populations. Information was offered in other languages and a telephone interpretation service was available and was also used for discussing consent. We were told that the division felt they were now up to speed with the needs of the eastern European population with accessible information, interpreting services and staffing.
The adult day unit staff were made aware of patients with learning disabilities beforehand by pre-assessment nurses and sisters sharing information. However, other staff told us there was no formal notification.

Carers were welcomed and patients shown to a quieter bay. We were given an example where one person was accompanied by two carers, was unable to speak but could understand. Time was taken to ensure information was understood. The trust had ‘easy to understand’ cards on the intranet which could be downloaded as an aide.

**Access and flow**

From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery remained similar to the average for England.

(Source: NHS England)

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, three specialties were above the England average and four specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>Average for England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>100%</td>
<td>65.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>77.7%</td>
<td>73.3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>77.2%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>69.2%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>62.3%</td>
<td>77.1%</td>
</tr>
<tr>
<td>ENT</td>
<td>54.9%</td>
<td>64.6%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>54.4%</td>
<td>61.7%</td>
</tr>
</tbody>
</table>

In October 2017 the trust returned to reporting referral to treatment time (RTT) for the first time since 2014. Reporting had been suspended between 2014 and 2017 so that the trust could fully investigate the issues and create a robust and comprehensive recovery plan. An extra 5000 operations and an extra 95,000 outpatient appointments had been undertaken to as part of the
recovery and improvement plan. The trust hosted a national conference about RTT to share their learning.

The performance report for theatres for December 2018 showed that trust wide data compliance against a trust target of 92% for referral to treatment (RTT) was recorded as a 12 month rolling trend rate of 78.5%. However, it also showed the last two month average to be 86%. There were ten patients waiting over 40 weeks and three over 50 weeks.

Every elective patient received pre-assessment. Patients were directed to one of the trust’s two acute hospitals that hosted the particular speciality. Pre-assessment was generally six to eight weeks prior to surgery. We found there were nine nurses working in pre assessment with all clinic rooms being utilised. There were 30 minute slots per patient three days a week and 40 minute slots two days a week for potential inpatients. Sometimes patients already had a date for surgery, sometimes not and were told at pre-assessment. They were two weeks for cancer patients and six to eight weeks for other patients.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed sporadic performance, and was mixed in comparison to the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Barking, Havering and Redbridge University Hospitals NHS Trust**

![Graph showing percentage of cancelled operations](image-url)
Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. (Source: NHS England)

Senior managers within the surgery division told us they had planned in September / October to reduce elective clinics for December / January. This was in order to free up theatre time and for doctors to be ward based. Extra fracture lists had also been added as part of winter pressures planning. There were meetings within the trust where the surgery division was represented and committed to the plan to manage winter pressures. We were told they had recently met to decide whether to extend the reduction of elective clinics. In terms of winter pressures, the surgery leadership did not feel as though the service had been stretched. It was reported that the new surgical assessment unit, based at the trust’s other acute hospital, had made a difference in managing winter pressures and had helped to keep the flow going.

On Dahlia ward we did not find any medical outliers on the ward. We were told they had taken some general surgery patients in the past but were currently free of outliers. On Iris ward an outlier board identified urology patients who were anywhere other than Iris ward within the hospital and who were to be reviewed daily. Senior managers within the surgery division told us that the placement of any outliers needed to be approved by an executive director or an on call lead.

There was an enhanced recovery pathway for hip and knee replacement patients which was a three to five day admission. On Iris ward we found good use of a flow model that created empty beds. Notes for red for blocked patients and green when patients are where expected on pathways. ‘Red and Green Bed Days’ were introduced on Iris ward as a visual management system to assist in the identification of wasted time in a patient’s journey. Its aim was to reduce internal and external delays as part of the patient flow bundle. We attended the 10am huddle on Iris ward that updated the multidisciplinary team following the morning ward round, facilitating early patient discharge.

Patients told us about delays in being taken to theatre from wards. In theatres, one patient told us they had to wait one and a half hours in recovery but that staff were apologetic and friendly. Another patient told us they came in at 7am and were told they were third on the list and then that they were first. However, they got in to theatre at 6pm and left at 10.40pm. They told us they had
been nil by mouth since 7pm the night before. We were told that staff were very apologetic and explained to the patient that the delay had been because the person who took the bloods at 8.30am had not taken them to the lab. Another patient told us they were admitted the day before at 10am and were advised they would be in theatre at 1.30pm, which ended up as 3.30pm. They told us they had waited another hour after that in theatre before their operation and were in recovery until 10pm.

Senior managers within the surgery division told us that the need for unplanned overnight beds from day surgery occurred ‘occasionally’ and was managed through operational meetings during the day. The 4pm operational meeting knew if any unplanned admissions were to take place, which would have been highlighted during the day. This would be known by midday and managed through systems and good contact with theatres. It was felt this was efficiently absorbed through capacity. However, unplanned admissions were not reported on within the performance reports.

It was reported that occasionally recovery was full due to the unavailability of beds on the ward. However, this was occasional. A frustration voiced by staff in recovery was that they could not get patients back to the ward as quickly as they would like. This was because the ward were not always ready to collect the patient. We were told that some wards were worse than others, which caused potential delays in getting patients out of theatre or may need to be recovered in theatre as a consequence.

The adult day unit worked to a two week turnaround from referral to appointment. Patients saw the doctor they were expecting to see and there was clear information, a clear plan with a date for pre-assessment. However, patients told us that they had issues with the flexibility of dates. There were no concerns about care but all patients had arrived at the same time. Staff told us that at 7am the patients arrived and were checked in. Before this they had been seen in pre-assessment and given information about the operation. We were told that waiting times could cause frustrations for patients, who needed an explanation but staff were unable to assure patients or update them regarding timings.

On the adult day unit, we were told there was sometimes a delay in patients being transferred to other wards for overnight stay. This delayed nurses going off duty particularly Wednesdays and Thursdays due to the nature of theatre lists.

**Learning from complaints and concerns**

From October 2016 to September 2017 there were 177 complaints about surgery which the trust took an average of 27 days to investigate and close. This was in line with their complaints policy, which stated that complaints should be closed within 25-40 working days.

At King George Hospital there were 30 of the trust’s 177 complaints, which were dealt with within an average of 26 days. A summary of complaints by subject is below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>King George Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>22</td>
</tr>
<tr>
<td>Communication</td>
<td>2</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Staff Attitude</td>
<td>2</td>
</tr>
</tbody>
</table>
In addition to the complaints process, surgical staff worked with patients to resolve issues that arose for them. A communication book was used on wards to record issues that had been raised by patients. Ward sisters dealt with resolving these individual issues. If patients felt they were still unresolved, the matron would work to resolve this. Staff also reported that PALS worked well within the surgery division and now had 100% of complaints and issues responded to within their ten day target. There was a patient complaints coordinator who worked with PALS who the leadership felt worked well.

**Is the service well-led?**

**Leadership**

The leadership structure within the surgery division covered both acute hospital sites of the trust. There was a triumvirate that consisted of the divisional nurse lead for surgery, the divisional manager for surgery and the divisional director who was the medical lead. The divisional director also attended the executive committee meetings, which was a sub-committee of the board. There was a deputy divisional manager and two specialty managers’ posts. One was based at King George’s and covered general surgery and urology. The other covered orthopaedic, ophthalmology, head and neck, ENT and maxillofacial and were based at Queens Hospital.

Both the divisional manager for surgery and the divisional director for surgery were leaving their roles. The divisional director had very recently stepped down to focus more on clinical work and was unavailable at the time of our inspection. The divisional manager was leaving the trust the week after our visit. At the time of our inspection, both posts remained unfilled although we were told the manager’s position was being interviewed for the week after. The divisional manager for theatres and anaesthetics was covering in the interim period.

In terms of ward leadership, there was a lead nurse who was the deputy to the divisional lead nurse. There were three matrons: one for urology and breast (based at King George Hospital), a general surgery matron and a specialty matron who were both based at Queens Hospital and worked across the sites. Each ward had a ward manager and a senior charge nurse. There was also a senior nurse for urology, a senior nurse for ophthalmology and a matron for quality and safety.

In main theatres, staff reported there was good support from the directorate leadership who were on a rota to come to the unit. The service manager was reported as coming every Wednesday. We observed the theatre manager as professional and helpful, managing his team in a competent...
way. However, theatre lists were inefficient, often starting late, finishing early and did not appear to be well coordinated. We found that theatre lists were inefficient and there was a lack of clinical leadership or coordination of theatre efficiency. There were a low number of cases on lists. Most lists did not start at the scheduled 8.30am. We documented late start times and early finishes which seemed to be accepted as the norm.

For example, on Tuesday 23 January 2018: Theatre 2 started 36 minutes late at 09:06. The reason for the late start was the surgeon was late to review patients. In theatre 4, (scheduled for 08:30 – 12:30) there was a 09:17 start and a 10:30 finish. The reason for the late start was the surgeon was late to review patients. It was not known why it finished early. In theatre 5 (scheduled for 08:30 – 17:30) there was a 09:45 start and a 14:00 end. Reason for late start was that anaesthetic time lasted 40 minutes. It was not known why it finished early. Theatres were poorly managed in this regard.

On Wednesday 24 January all five theatres in use started late. We documented the following: Theatre 1 started at 09:26 due to the patient not ready in ward. Theatre 2 started at 09:25 due to anaesthetic time 38 minutes. Theatre 3 started at 09:30 due to anaesthetic time 33 minutes. Theatre 4 there was no morning list. Theatre 5 started at 11:30am the patient was still in anaesthetic room due to a delay in organising an ITU bed. However, this issue had been addressed by 10am and the patient was still in the anaesthetic room 90 minutes later. Theatre 6 the list had not started yet as the surgeon was involved in an emergency in ITU.

**Vision and strategy**

Trust values were passion, responsibility, innovation, drive and empowerment – PRIDE. All staff were expected to undertake PRIDE training, which raised its profile and involved understanding how core values were relevant to each area of work. 95% of staff had completed this training within the surgery division at King George Hospital. Pride values cards were attached to name badges of staff. The vision was underpinned by five key objectives: delivering high quality care, running our hospitals efficiently, becoming an employer of choice, managing our finances, and working in partnership.

The trust stated in their Quality Account 2016 – 2017, that the overall strategic direction following exit from special measures was to continue to build operational resilience required for strategic change and long-term sustainability. Within this it was proposed that King George Hospital became a centre of excellence for elective care, long-term conditions and care of the elderly.

**Culture**

In main theatres staff told us they valued teamwork and the friendly atmosphere. We were told they managed better because they were a team and all roles and grades were respected. Recovery also told us they appreciated the team work ethic and the atmosphere this generated.

On surgical wards, staff told us it was a friendly, respectful trust. The adult day unit also told us there was good team work with good support from managers. Medical staff were also described as respectful.

**Governance**
Following our last inspection in 2015, we recommended that the audit programme in surgery was reviewed so that internal audits were completed and implemented. Since our previous visit the arrangements had been greatly improved. However, this was not fully embedded and further work was needed.

The monitoring and completion of internal audits in the surgery division had been reviewed and were reported at the monthly quality and safety committee meetings. Staff we spoke with told us that an external independent review was commissioned and showed us the report of the review which stated that there was an uncoordinated approach and lack of systems in place to manage, monitor and report on clinical audit.

Following the review a number of recommendations had been acted upon by the trust. A clinical audit and effectiveness strategy and a clinical audit policy were published in December 2016 to clarify roles and responsibilities. In addition, dedicated staff had been appointed to lead the implementation and monitoring of the audit programme. They included managers, an interim clinical audit manager for the trust, a divisional quality and safety matron who worked between Queen’s hospital and King George hospital, and departmentally based quality and safety leads. However, the post holders had been in position between one and four months at the time of our inspection, which meant we were not able to fully assess their impact.

Other staff spoke positively of the appointments and were optimistic that audits would take place and learning would be shared. An annual audit programme entitled Learning from Our Care had been agreed by clinical audit leads, and was scheduled from January 2018 until January 2019 on a four weekly cycle. Scheduled audits included nursing documentation, falls and wristband audits, completion of safety thermometer, completion of MUST nutritional assessment scores and hand hygiene audits.

Senior nurses, therapists and managers told us that they felt there had been significant improvements in the monitoring of clinical practice through peer review and audit by staff working in other areas in the trust, as well as members of the quality and safety team. They were able to provide examples of a range of audits carried out by a range of staff; however, the reporting systems were not fully embedded and lack of learning from audits remained an identified risk on the risk register. Staff told us that they were confident audits were taking place regularly but described the audit process as ad hoc in some areas. Staff and managers also told us there was often a lack of documentary evidence to demonstrate audits had been completed. A manager told us that the trust had invested in an electronic system to ensure there was a more co-ordinated approach. This was set up on the hospital intranet in April 2017 to provide evidence of the audits completed. However, we asked to see the register and saw that no entries were recorded on the system since its introduction. The manager that showed us the system confirmed this to be the case. Staff we spoke with felt that this was partly due to a lack of training and lack of protected time to input data. Another manager told us the lack of recorded evidence was an historical issue in the trust and that paper copies of audits would be held at departmental level. We asked to see these documents and saw that this varied from department to department, and that there was still an uncoordinated approach.

The divisional quality and safety meeting was chaired by the divisional manager for surgery and attended by quality and safety governance leads, specialty managers, the NICE and mortality lead and the quality and safety matron. Each specialty within surgery had a quality and safety meeting and reported into this meeting. Its function was to report surgery issues and performance into the trust wide quality governance steering group which was chaired by the chief nurse. The risk register and quality performance report were reported by division and both reported into this meeting as well as the divisional quality and safety meeting. At ward level, huddles took place and
wards were represented at local quality and safety meetings. Ward staff told us that ward meetings took place every four to six weeks.

There were six sub specialties within the surgery division that had a clinical lead and governance leads known as quality and safety leads. The six were ENT, maxillofacial, urology, orthopaedic, ophthalmic and general surgery. The latter four took place at KGH, with urology taking place exclusively. The anaesthetics division had responsibility for theatres. It followed the same governance structure, with sub specialities of pain, theatre and critical care.

**Management of risk, issues and performance**

Monthly performance reports were reported in to divisional quality and safety meetings and into the trust wide quality governance steering group.

The anaesthetics division, which included theatres, reported on: emerging issues, key achievements, top risks, NatSSIPs (National safety standards for invasive procedures), tracking, finance, Divisional Improvement Walk’s and External Visits, strategic priorities, quality of care, patient experience, incidents, ward scorecards, pain management, anaesthetics, theatre cancellations, use of resources, RTT, vacancy rates and training.

Minutes of the divisional quality and safety meetings for both divisions were reviewed. The anaesthetics division’s safety report was reviewed in the meeting and included incidents, risk register, MRHA, safeguarding, mortality, NICE and patient experience. Minutes showed meaningful discussion on key issues and an action log with named leads.

Surgery reported on: emerging issues, key achievements, top risks, quality of care patient experience, incidents, ward scorecards (with themes and trends), incidents and audit), activity (elective, non-elective, day case, length of stay, non-attendance, use of resources, referral to treatment and patient flow, leadership and recruitment, training and appraisal. Minutes of the quality and safety meeting for surgery showed a review of the performance report and a review of the action and monitoring log.

Top risks for the division were reported on in the monthly performance reports for anaesthetics, who also had responsibility for theatres. One of the two risks reported in September 2017, was lack of assurance for the WHO checklist and the theatre count process for swabs, instruments and devices. Progress was reported as swab count standard operating procedure had been rewritten and approved by the divisional quality and safety group in August 2017. Training sessions in theatre team meetings and carrying out multidisciplinary simulation sessions were reported as completed tasks.

Risk registers were maintained in both surgery and anaesthetics divisions, with top risks summarised within the monthly performance report that was reported in to divisional quality and safety meetings and into the trust wide quality governance steering group. All identified risks had a ‘risk owner’ and were risk rated, with date of last review and next review stated. Top risks were reported in to the divisional quality and safety meeting minutes needed.

With audit processes, senior managers within the surgery division told us they were ‘less assured’. There was an audit lead for each specialty and two posts had been vacant for a period and only
recently recruited to. There was an audit programme that had not been fulfilled due to vacancies as well as lapsing of the programme. We were told that audit processes had been moved onto an electronic system which had also caused lapsing. The lead nurse was working with the audit department and with a plan of action to scope current state and prioritise actions. This was reported to the risk register and to the quality and governance steering group.

Progress with National Safety Standards for Invasive Procedures (NATSSIPs), were reported on in the monthly performance report, which was reported into divisional quality and safety meetings and into the trust wide quality governance steering group. The standards supported NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. The standards reported on were: intubation, catheter/vascaths lines, Laryngeal mask airway insertions, placement of throat packs, arterial lines, awake fibre optic intubation, pain procedures, epidurals, spinals and peripheral nerve blockade. Each standard had a named lead and progress was RAG rated. Out of the ten, five were rated as green with two amber and three red. Completion dates were identified as October 2017 for amber rated issues and November 2017 for red.

Staff we spoke with told us that an external independent review was commissioned and showed us the report of the review which stated that there was an uncoordinated approach and lack of systems in place to manage, monitor and report on clinical audit. Following the review a number of recommendations had been acted upon by the trust. A clinical audit and effectiveness strategy and a clinical audit policy were published in December 2016 to clarify roles and responsibilities. Dedicated staff had been appointed to lead the implementation and monitoring of the audit programme. They included managers, an interim clinical audit manager for the trust, a divisional quality and safety matron who worked between Queen’s hospital and King George hospital, and departmentally based quality and safety leads. However, the post holders had been in position between one and three months at the time of our inspection, which meant we were not able to fully assess their impact. Other staff spoke positively of the appointments and were optimistic that audits would take place and learning would be shared.

An annual audit programme entitled Learning from Our Care had been agreed by clinical audit leads, and was scheduled from January 2018 until January 2019 on a four weekly cycle. Scheduled audits included nursing documentation, falls and wristband audits, completion of safety thermometer, completion of MUST nutritional assessment scores and hand hygiene audits.

Matrons and other managers from the divisional triumvirate were scheduled into a rota to conduct weekly ‘improvement walkabouts’ in clinical areas at different times of the day and night to monitor the environment and see what could be improved. We saw these had been completed every week. Examples of issues they had identified included storage of records and non-compliance with the bare below the elbow policy. We saw these issues were fed back to staff at the time who had acted upon them. We saw each department had a ‘fit to fly’ folder which contained a range of safety checklists that were completed as part of the risk assessment and management at the start of each shift. Staff at all levels knew where to locate the folder and had participated in the checks.

An annual quality account report was published by the trust. Progress reports on each of the quality improvement priorities were identified and reported to the quality governance steering group, and ultimately the trust board.

Engagement
A patient experience strategy was developed in 2016 following engagement with a cross section of the local community to help set priorities. The strategy comprised three strands: listening and responding to feedback, working with patient partners, and improving accessibility to services for people with disabilities. Four out of seven of the surgical wards across the trust achieved a score for positive patient experience of 96% consistently.

The trust engaged with patients through a newly established Patient Partnership Council. We saw a number of volunteers worked across the organisation, including a patient partner who worked across the surgical division. Staff also told us that selected patients would visit patients undergoing similar surgery, for example.

We were told the trust had a ‘patient partner’, who worked across surgery and with the trust’s patient experience lead. They had worked on initiatives such as bare below the elbows work. They were also working with the lead nurse for surgery and looking to recruit a patient representative to consult for design of the new building.

On surgical wards, positive comments from friends and family results were on display, as were plans to address negative comments.

The staff survey that took place at the end of 2016 reported a lack of leadership visibility and prompted a number of actions. They included a monthly newsletter reported on events and on work undertaken. There was a star of the month scheme within each division to recognise work. All new starters had tea with the triumvirate leadership within the division as part of their introduction. A drop in session occurred monthly at alternate sites with the leadership and looked at change. There were also walk arounds by the leadership within surgery. An engagement action plan was reported in the monthly performance report.

Staff we spoke with were positive regarding leadership team’s engagement. For instance, on Dahlia ward we were told that senior staff were approachable and supporting. On Iris ward we were told the divisional lead nurse for surgery visited the ward regularly and were very supportive, that the chief nurse did spot checks during the night and spoke with staff regarding their experience of working at the trust. We were also told that the chief executive visited the ward each month. On Heather ward staff spoke positively about the ward manager for good patient care, and that they had high standards and expected professionalism from staff.

**Learning, continuous improvement and innovation**

Senior managers within the surgery division identified the following as innovative work:

Introduction of ‘Red and Green Bed Days’ on Iris ward, which were a visual management system to assist in the identification of wasted time in a patient’s journey. Its aim was to reduce internal and external delays as part of the patient flow bundle.

Introduction of a prostate diagnostic pathway incorporating multi-parametric MRI scans (mpMRI). An mpMRI scan before a biopsy can radically improve the accuracy of the diagnostic process for prostate cancer. Because of this it has the potential to drive improvements in patient outcomes and experience.

Introduction of targeted biopsy for prostate cancer diagnoses. The prostate is examined with MRI to look for areas that look abnormal and are more likely to contain cancer. Then an ultrasound is done with special equipment that matches the ultrasound images with the MRI in real time. This allows the doctor to target the abnormal areas for biopsy.
Introduction of straight to test for colorectal cancer assessment. The 'straight-to-test' programme streamlined the process so that patients who are assessed as being suitable can be given an appointment for colonoscopy or flexible sigmoidoscopy without the outpatient appointment first. This streamlined process reduces waiting times for patients from the date of their referral until the date of their test and may also mean that they receive treatment for cancer more quickly.

The development of transanal total mesorectal excision (TME) of the rectum for rectal cancer across both sites, supported by four consultants who have undergone training for this procedure. Transanal total mesorectal excision aims to improve the clinical outcome of rectal excision, and to reduce the length of stay in hospital and morbidity after surgery.

Introduction of a new consultant appointed to develop pelvic floor unit at the trust from April 2018. The pelvic floor service has been an important area relating to improved management of incontinence. For many years the trust were reliant on patient assessment taking place at other London trusts and complex pelvic floor and colorectal problems were being sent to a tertiary centre.

Senior managers within the surgery division also identified the work carried out on their first year medical trainee (FY1) educational programme as innovative working. The trust lost its FY1s in November 2016 when Health Education removed them due to the quality of the training. However, they returned them in April 2017 and complimented the trust on the educational programme that was put in to place to support them.