Barking, Havering and Redbridge University Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement 
Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	**Requires improvement** 

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

King George Hospital opened at its current site in Ilford in 1995 and provides acute and rehabilitation services for residents across Redbridge, Barking & Dagenham, and Havering, as well as providing some services to patients from South West Essex. The hospital has approximately 450 beds.

The trust had an annual revenue of around £560 million and projected year-end deficit of £11.9 million, at the time of the inspection. The trust employs 5,713 staff, with a budget for 6,676 staff. The trust provides a full range of adult, older people's and children's services across medical and surgical disciplines.

Over a twelve month period the trust reported activity figures of 101,685 inpatient admissions, which is made up of 52,536 emergency admissions and 49,149 elective admissions. Between the period of October 2015 and September 2016 there were 829,011 outpatient attendances, 280,795 attendances through the Accident and Emergency (A&E) department.

The CQC undertook a comprehensive inspection of Barking, Havering and Redbridge University Hospitals NHS Trust in October 2013 and found serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. Following this inspection, the trust was placed in special measures in December 2013.

A further comprehensive inspection took place in March 2015. In this inspection it was recognised that progress had been made, however the trust continued to carry significant risks and therefore remained under special measures. Overall the trust was rated as requires improvement, with the responsive domain rated as inadequate.

We carried out an unannounced inspection of three core services between the 7th and 8th September 2016. We then carried out a further announced core service inspection, alongside a well led assessment between the 11th and 12th October 2016.

In March 2015 we rated the organisation as requires improvement. Following the recent core service inspection and well led review, the trust remains rated as requires improvement.

This inspection was specifically designed to test the requirement for the continued application of Special Measures to the trust. Prior to inspection we risk assessed services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment led us to include four services (emergency care, medical services, outpatients and diagnostics and services for children and young people) in this inspection which were inspected at Queens Hospital and the King George Hospital. The remaining services were not inspected as they had indicated strong improvement at our last inspection and our information review indicated that the level of service seen at our last inspection had been sustained.

In our most recent inspection we were particularly encouraged by the significant improvements that have been made by the trust since March 2015. Our overall rating for the trust is now requires improvement and there are no areas rated Inadequate.

We were particularly encouraged by the improvements made in a number of areas.These were

- Improvements in a number of domains within the services that we inspected since our last inspection.
- Improvements in the overarching governance processes.

Queens Hospital

Summary of findings

In March 2015 we rated the urgent and emergency care service as requires improvement overall, with an inadequate rating for the safe domain. Following our recent review we have rated urgent and emergency care at Queens Hospital as requires improvement across the five domains.

In March 2015 medical care was rated as requires improvement within the safe, responsive and well led domains. Following the September inspection we recognised the progress made within the well led domain, along with the continued performance in the effective and caring domains, which we rated as good. The safe and responsive domains remain as requires improvement, resulting in an overall rating of requires improvement for medical care.

In March 2015 we rated services for children and young people as requires improvement, with an inadequate rating for the responsive domain. Following the October inspection we rated services for children and young people as good, with the safe domain rated as requires improvement.

In March 2015 we rated outpatients and diagnostics as requires improvement, with an inadequate rating for the responsive domain. Following the September inspection we rated this service as good, recognising progress in the safe, caring and well led domains which we rated as good.

King George Hospital

In March 2015 urgent and emergency care was rated as requires improvement across all domains. Following the September inspection we rated this service as requires improvement, recognising the progress made within the caring and responsive domains which we rated as good.

In March 2015 medicine was rated as requires improvement across four domains (safe, effective, responsive and well led). Following the September inspection we rated medical services as requires improvement, with the caring and well led domains rated as good.

In March 2015 outpatients and diagnostics was rated as inadequate. This service received two ratings of inadequate under the safe and responsive domains. Following the September inspection we rated the service as requires improvement, recognising progress in the caring and well led domains which we rated as good.

The rating for well led has remained at requires improvement as ascribed in the 2015 inspection. However, the senior leadership team were visible and involved in clinical activity. Time and resource had been invested into improving clinical governance structures and risk management and the trust actively promoted innovation and improvement to the patient experience.

It is apparent that the trust is on a journey of improvement and significant progress is being made both clinically and in the trust's governance. It is also clear that there is still further work to do to ensure that these improvements are sustained and that further progress is made.

Our key findings were as follows:

Are services safe?

- Compliance with infection prevention and control (IPC) practices across the services we inspected were found to be inconsistent.
- Rates of Methicillin-resistant Staphylococcus aureus (MRSA) infections had breached the trust zero tolerance target for the year.
- Fire safety standards in CYP services, including areas around the NICU were not always maintained.
- The emergency department (ED) cooling system at the King George Hospital had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs.
- Although nursing staffing levels had improved since the last inspection, some areas still had significant vacancy and turnover rates.
- We found high usage of locum across the organisation. Feedback from some locums was that access to training was poor and we had concerns that this meant they might not be appropriately skilled with up to date competencies.
- Since our previous inspection in March 2015 the organisation had improved its' processes around incident reporting across both sites and staff told us that they were encouraged to record incidents.

Summary of findings

- The inspection raised concerns about the diagnostic imaging department at the King George Hospital not comply with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Ionising Radiation Regulations 1999 (IRR99).

Are services effective?

- We found a number of clinical guidelines on the trust intranet were out of date. There was also issues with access to trust policies and guidelines for agency staff who had no computer access.
- The ED's performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock, asthma in children, and paracetamol overdose.
- In medicine at Queens Hospital we found there was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- For non-elective medicine admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine.
- Clinical staff completed a variety of local audits to monitor compliance and improvement. Staff of all levels told us that these led to meaningful change across the service.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. Actions had been taken to improve the service in those measures where they were underperforming.

Are services caring?

- The majority of patients were positive about the care they received and we observed courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- We observed some negative interactions in the ED at Queens Hospital. We also observed a patient calling out for help and was ignored until we escalated to the nurse in charge.

Are services responsive?

- The percentage of patients being seen and treated within the ED recommended four hour timeframe at both hospital sites and the number of patients who left the department without being seen was worse than the national average.
- In medicine at the King George Hospital patients were not always able to be located on the specialist ward appropriate for their condition. In some wards, bed moves were consistently occurring out of hours (between 10pm and 6am).
- Environments on some wards in the King George Hospital were not ideal, with high levels of noise and heat observed and reported. There was a lack of bedside televisions or radios across the wards, which some patients reported made them feel isolated and bored.
- The trust was consistently failing to meet NHS waiting time indicators relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance.
- The trust was not meeting 18-week waiting time indicator for non-urgent referral to treatment (RTT) times.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
- The ED's at both sites worked closely with local GP's to stream patients effectively, including back to their own GP.
- People living with dementia received tailored care and treatment. Care of the elderly wards at the King George Hospital had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help.

Are services well led?

- Senior Leadership was visible and involved in clinical activity. Staff were positive about changes and were starting to feel more optimistic.
- Time and resource had been invested into improving clinical governance structures and risk management since the past inspection in March 2015.
- Quality improvement and research projects took place that drove innovation and improved the patient experience.

Summary of findings

We saw several areas of outstanding practice including:

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to m ake their stay in hospital easier and reduce any emotional distress.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which improved the quality of life for families.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

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

Importantly, the trust must:

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

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve paediatric nursing capacity.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores.
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes.
- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Review out-of-hours provision of services and consider how to more effectively provide a truly seven day service.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.

Summary of findings

- Make patient information leaflets readily available to those whose first language is not English.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average.
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- There is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.
- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Barking, Havering and Redbridge University Hospitals NHS Trust

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

In the 2015 indices of multiple deprivation, Barking and Dagenham was ranked in the most deprived quintile. Havering and Redbridge were both ranked in the third (middle) quintile.

The trust had an annual revenue of around £505.2 million and projected year-end deficit of £33.6 million, at the time of the inspection. The trust employs 5,713 staff, with a budget for 6,676 staff. The trust provides a full range of adult, older people's and children's services across medical and surgical disciplines.

Over a twelve month period the trust reported activity figures of 101,685 inpatient admissions, which is made up of 52,536 emergency admissions and 49,149 elective admissions. Between the period of October 2015 and September 2016 there were 829,011 outpatient attendances, 280,795 attendances through the Accident and Emergency (A&E) department.

We inspected four of the core acute services including: urgent and emergency care, medical care (including older people's care), services for children and young people, and outpatients and diagnostic services, at both the Queen's Hospital and King George Hospital sites. In conjunction with the core service review, we carried out a well led review of the trust.

Our inspection team

Our inspection team was led by

Chair: Dr Bill Cunliffe, secondary care clinician, Newcastle Gateshead CCG Team Leader: Nicola Wise, head of hospital inspection, Care Quality Commission

The trust was visited by a team of CQC inspectors and a variety of clinical and non-clinical specialists. There were consultants in emergency medicine and medical care. The team also included nurses with backgrounds in medicine and outpatients. The trust-wide team consisted of specialist advisors with board-level experience and national regulatory experience.

How we carried out this inspection

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

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

As part of this bespoke re-inspection the inspection team carried out an unannounced inspection of the following core services:

- Urgent and emergency services
- Medical care (including older people's care)
- Outpatients and diagnostic imaging

In addition to this, the inspection team carried out an announced inspection of:

- Services for children and young people.

Summary of findings

• Well led review

As part of inspection we: observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals, including doctors, nurses, allied health professionals, administration, and other staff. We also interviewed senior members of staff at the trust.

What people who use the trust's services say

NHS Friends and Family Test

Barking, Havering and Redbridge University Hospitals NHS Trust have consistently maintained a higher response rate to the NHS staff survey in the preceding twelve months prior to our inspection. In September 2016 the trust achieved a response rate of 39%, compared to an England average of 23.9%.

The percentage of respondents who would recommend the trust was consistently below the national average for the preceding twelve months, with September indicating that 92.9% of respondents would recommend the trust, compared to a national average of 95.4%.

Facts and data about this trust

Barking, Havering and Redbridge University Hospitals NHS Trust is large acute trust with around 1139 beds, serving approximately 750,000 people living in Barking, Havering and Redbridge and the surrounding areas. It employs around 5,713 staff that deliver care across two acute hospital sites.

Key Figures

Beds:

King George Hospital:

283 inpatient and 26 day case beds

Queens Hospital

830 inpatient and 71 day case beds

Staffing as of 1st April 2016**:**

5,713 WTE (against an establishment of 6,676 WTE)

849.5 medical (against an establishment of 920)

1,922.2 nursing (against an establishment of 2,100)

336.1 allied health professionals (against an establishment of 368)

1,418.4 other (against an establishment of 1,577)

Financial data 2015/16

Revenue: £505.2 million

Full Cost: £569.6 million

Deficit: £33.6 million

Activity type 2015/16

Inpatient admissions 101,685, ff which there were

Emergency admissions: 52,536

Elective admissions: 49,149

Outpatient (total attendances): 829,011

Accident & Emergency (total attendances): 280,795

Is this trust well led?

Staff sickness

The trust's sickness levels between May 2015 and April 2016 were lower than the England average.

Staff turnover

The trust's staff turnover of nurses was 359. The turnover of medical staff was 114. The overall percentage cannot be provided due to the format of the data provided by the trust. The trust did not provide the date range for the data provided.

NHS staff survey results

Summary of findings

In the 2015 NHS staff survey the trust scored higher than the England average for acute NHS trusts, against the following measures:

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Against both of these questions there was no significant difference between white or BME staff.

Against question KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

The results showed that 82% of staff from a white ethnic origin responded positively, compared to 64% of BME staff.

Against question Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

Response rates indicated 9% from a white ethnic background responded positively, as opposed to 18% of BME staff.

In the 2016 staff survey the trust had improved the staff response rate by 6.2% from the previous year. Compared with other organisations the trust scored the same as or better on 60 of the 88 measures.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We examined the safe domain in the context of the core services that we inspected but for the purpose of this report we did not rate it. • We observed poor compliance with infection prevention and control (IPC) practices in multiple areas. Hand hygiene audits across the trust showed compliance in some areas to be poor. • Rates of Methicillin-resistant Staphylococcus aureus (MRSA) infections had breached the trusts' zero tolerance target for the year. • There was poor recognition of and response to patients with suspected sepsis in the ED at King George Hospital. • The ED cooling system at the King George Hospital had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs. • There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services. • We found high vacancy rates for nursing positions across the organisation. There was a high rate of senior band six nurse vacancies in the ED at Queens Hospital. The service had over recruited on band 5 nurses to compensate for this gap. However, band 6 nurses are often more experienced and therefore we had concerns regarding the skill mix. • We found high usage of locum across the organisation. This was particularly high in the ED's at Queens Hospital and King George Hospital there was a high usage of locum medical staffing for consultants and middle grade doctors. Feedback from some locums was that access to training was poor and we had concerns that this meant they might not be appropriately skilled with up to date competencies. • Compliance with resuscitation training in both the ED at Queens Hospital and King George Hospital was poor. We had no assurance that locum medical staff had up to date resuscitation training. • In services for children and young people the neonatal unit (NICU) did not always meet the minimum staffing requirements of the British Association of Perinatal Medicine. However,	

Summary of findings

- Since our previous inspection in March 2015 the organisation had improved its' processes around incident reporting across both sites and staff told us that they were encouraged to record incidents.
- Staff were aware of their responsibilities with regards to Duty of Candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan.
- Staff had a good understanding of their roles and responsibilities with regards to safeguarding adults and children.
- We found a lot of educational work around sepsis pathways and the early identification of sepsis was in place in the ED at Queens Hospital.
- The trust had changed their electronic system records system and introduced the electronic patient record (EPR).

Incidents

- We found systems for reporting and learning from incidents across services. Staff were aware of how to report patient safety incidents and knew about the trust-wide electronic system for incident reporting. However, agency staff had no access to trust computers and relied on permanent staff to complete incident forms for them.
- Serious incidents (SI) are those that require investigation. Data provided by the trust showed in the ED at Queens Hospital there were 10 SI's which had breached their internal deadline.
- Most staff were able to describe action points from incidents and changes in practice as a result of learning.
- We saw examples whereby learning from incidents had been encouraged, for example through email and intranet messages, as well as 'keep in touch' days, which were held four times per year, where SI's were discussed.
- Patient Safety Summit meetings were held every week and attended by multidisciplinary staff from all divisions and co-chaired by the Medical Director and Chief Nurse. The focus of these meetings was to review recent serious incidents or a case study presentation and discuss what could be learnt and shared more widely to prevent a similar incident happening again.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant

persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff that we spoke with understood the term 'duty of candour' and their responsibilities in relation to this.

- Mortality and morbidity was considered during the monthly mortality assurance group. This group was introduced in 2015 as part of the 'sign up to safety' initiative, which aimed to improve the monitoring and identification of mortality outliers to identify potential areas where deaths could be prevented.
- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R and to the Health and Safety Executive (HSE) under the Ionising Radiation Regulations 1999 (IRR99). Diagnostic and imaging services had procedures to report incidents to the correct organisations, including CQC. At the time of the inspection, there were two open cases with the CQC which were also classified as SI's. We saw evidence that these were being dealt with appropriately with review meetings, action plans and wider learning.

Cleanliness, infection control and hygiene

- The trust had up to date policies and procedures for hand hygiene and infection prevention and control (IPC).
- Each ward / clinical area had an IPC link nurse. The link nurse acts as a link between the clinical area and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice. There was also a lead IPC nurse for the trust and head of IPC, who staff were aware of and knew how to contact if necessary.
- Infection control audits were completed by the Infection Prevention and Control team (IPCT), with frequency depending on the score the area had achieved in a baseline audit at the beginning of the year.
- Hand hygiene audit data submitted to the CQC for August 2015 to August 2016 showed that there to be high variability in adherence to hand hygiene practice. With the results in the ED's at both sites, and some of the medicine wards, being consistently poor.
- There were dispensers with hand sanitising gel across the organisation. However, we found a number of empty dispensers during the course of our unannounced inspection including the ED's at both sites, some areas of medicine and the outpatient departments.
- During our inspection, we observed staff in a number of departments did not consistently comply with hand hygiene

practice. Not all staff regularly cleaned their hands as they moved from one area to another, or when leaving or entering departments. This was raised as a consistent issue in a cross-section of staff meeting minutes that we reviewed.

- We found evidence of non-compliance with IPC rules for isolated patients. We observed a patient within medicine at the Queens Hospital site who had been isolated due to an infection of carbapenemase-producing Enterobacteriaceae (CPE) infection. Enterobacteriaceae are a family of bacteria, many of which live naturally in the bowels. These bacteria produce carbapenemase enzymes that can break down many types of antibiotics, making the bacteria very resistant. We noticed the isolation room door left open on more than one occasion, despite alerting this issue to a staff member.

Environment and equipment

- The cooling system in the ED at the King George Hospital was not working on the day of our inspection. There were fans strategically placed around the department to mitigate this. Staff told us this had been recorded as an incident three weeks earlier. We were told that it had made working conditions very challenging for staff during periods of hot weather. There was a lack of clarity as to when this situation would be addressed.
- We saw this had been added to the corporate risk register on the first of August, with a review date set for October. The risk register referenced the fact that drugs fridges were unable to remain within safe temperature limits which resulted in medication wastage.
- We noted that the drugs room temperature in the ED had reached a maximum temperature of 25 degrees. There were fans in situ to control the temperature and we saw an action plan in place should the temperature exceed 25 degrees on seven consecutive days.
- In medicine services at the King George Hospital patients commented that the wards could be very noisy at night. We observed that Fern ward was quite unsettled in the morning, with lots of corridor traffic and high noise levels.
- 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. At the time of inspection, approximately 70% of repair work had been undertaken but some breaches still existed and were not expected to be repaired fully until summer 2017. This issue had been added to the corporate risk register.
- In outpatients at the King George Hospital the audiology room venting system was not working. The room was small and did

not have any other means of ventilation such as windows. We saw a patient experience an episode of dizziness and breathlessness in the room, which the patient felt was due to a lack of air in the room. We were informed by staff that this issue had been highlighted as an issue but had not been resolved.

- In CYP services a secure corridor linked the neonatal intensive care unit (NICU) with the main hospital and contained a kitchen. On one day of our inspection we found both fire safety doors between the corridor and the kitchen were wedged open and the kitchen was unattended. This meant if the fire alarm sounded, the automatic door closure mechanism would fail to operate. There was also no firefighting equipment in the kitchen. A member of catering staff told us there was no fire safety equipment in the kitchen and said they did not know where the nearest fire extinguishers were.

Records

- The trust had changed their electronic records system in December 2015 with the introduction of the electronic patient record (EPR), having previously used the patient administration system (PAS). The EPR provided staff with access to patient letters, reports, imaging and test results. However, most patient records were paper based, including risk assessments. Most staff we spoke with commented positively on the EPR.
- The trust had launched 'iFit' a records management system in to address identified issues in regards to missing information in patient records, the over use of temporary records, and the tracking of patient records. Outpatients' department staff had completed workshops on the iFit system. Staff we spoke with confirmed records management had improved and there was decreased use of temporary records.
- In most areas we found that records were kept in lockable trolleys. However we also found sets of patient notes in an unlocked and unsupervised room which was accessible by the public. This was brought to the attention of the service lead and the room subsequently locked.

Safeguarding

- In line with statutory guidance the trust had named nurses and named doctors, and safeguarding teams for child protection and safeguarding vulnerable adults.
- The safeguarding adult and children policies were available on the trust intranet and were up to date. Safeguarding was part of the trust annual mandatory training.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding adults and children. Staff were able to

give us examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.
- All staff we spoke with knew the safeguarding team and could identify where to find the contact details if required.
- There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes were shared.
- Staff had a good understanding of female genital mutilation (FGM) and knew they could access the safeguarding lead for any support.
- However in the ED at the King George Hospital completion of safeguarding training by doctors was low. Compliance with safeguarding adults level 2 was 73% and safeguarding children level 3 was 60%.

Assessing and responding to patient risk

- Ambulance turnaround time did not meet the national standard of handover for the ED at the King George Hospital. The standard for ambulance handover is 95% within 15 minutes. This means that they should have an initial assessment with a nurse or doctor. The percentage of patients seen within 15 minutes between August 2015 and August 2016 averaged 52%, with the lowest average at 39.8% in March 2016.
- We found a lot of educational work around sepsis pathways and the early identification of sepsis was in place in the ED at Queens Hospital. However, we had concerns around staff awareness of sepsis and the early identification of sepsis in the ED at the King George Hospital.
- The hospital used a national early warning score (NEWS) system to identify when patients were deteriorating using variations in different observations such as heart rate, blood pressure and oxygen levels. Patient records we reviewed showed patient observations were completed.
- The hospital used the paediatric early warning scores (PEWS) system to monitor patients for signs of deterioration. PEWS were completed at regular intervals based on the condition of the patient and staff escalated patients with an increasing score to an appropriate doctor. Each patient records folder included the protocol for caring for a child between one and ten years old in cardiac arrest, which followed Resuscitation Council (UK) guidance.

- Patients at risk of deterioration were discussed in daily safety huddles or board rounds, where members of the multidisciplinary team (MDT) gathered to review individual patient treatment plans and conditions.

Staffing

- The trust had vacancies across all staff groups, however mitigation plans were in place to ensure staffing levels met minimum requirements with the use of bank, agency and locum staff. Staff who we spoke with told us how staffing had improved since the previous CQC inspection in March 2015.
- The Trust used the Safer Nursing Care Tool (SNCT) as an indicator for safe staffing levels across relevant ward areas within the Trust. This tool calculated serious staffing deficiencies and these were flagged as 'black' risks to signal a concern within the given area.
- Wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the numbers of staff available that day and whether this met the planned requirement. This was in line with Department of Health guidance.
- Within the ED at Queens Hospital we found a 47% vacancy rate for senior band six nursing posts. The department had mitigated against this risk through additional recruitment of band five nursing, however we had concerns regarding the skill-mix of the nursing establishment.
- National standards for children and young people in emergency care settings state that there must be a nurse with advanced paediatric life support qualification on each shift. We found, in the ED at Queens Hospital, that 35% of shifts within the prior three months had not met this standard. The lack of adequate paediatric nursing capacity was rated as high on the recent corporate risk register.
- We found high rates of Consultant vacancies across the organisation. Within the ED there was a 40.6% vacancy rate for Consultant posts who worked across both hospital sites. Locum posts were utilised to cover this shortfall in substantive staff numbers.
- During the week and weekend the emergency department had consultant cover between the hours of 8am and till midnight. This ensured the department was meeting the Royal College of Emergency Medicine (RCEM) standard around consultant presence. The RCEM states that there should be a consultant

present for a minimum of 16 hours a day. The department had recently introduced consultants who worked during the night, which meant on some days there was 24 hour consultant presence.

- We found a high number of middle grade doctor shifts filled by locums across both the ED's and Queens Hospital and the King George Hospital. Senior leaders told us there were challenges in recruiting middle grade doctors to the department.
- Locum medical staff are fully qualified doctors but they do not always have the specialist skills required for treating patients in emergency situations. We spoke to some locums during the inspection who told us they could not access training in the same way junior doctors could. We were told since the junior doctors had left the weekly training sessions had stopped taking place. This meant there were no assurances that their clinical skills were up to date. We asked the trust how they monitored whether locum staff had up to date advanced life support training. We were told this was done via a third party. The trust were unable to provide us with assurance that locum staff had appropriate resuscitation training.
- A trust recruitment and retention group had been established and met monthly to drive action and monitor progress in recruitment.

Are services at this trust effective?

We examined the effective domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

- The majority of patients were assessed for pain and offered appropriate pain relief.
- Clinical areas, such as the ED at both sites ran multidisciplinary keeping in touch (KIT) days in order to provide staff with training for their development.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement. Staff of all levels told us that these led to meaningful change across the service.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate.

Summary of findings

- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. Actions had been taken to improve the service in those measures where they were underperforming.

However,

- We found a number of clinical guidelines on the trust intranet were out of date. There was also issues with access to trust policies and guidelines for agency staff who had no computer access.
- The ED department at Queen Hospital performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock, asthma in children, and paracetamol overdose.
- In medicine at Queens Hospital we found there was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- For non-elective medicine admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine.
- We had concerns about the diagnostic imaging department not complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Ionising Radiation Regulations 1999 (IRR99).

Evidence based care and treatment

- The organisation used National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided to patients.
- We found a backlog of of NICE guidance that was awaiting confirmation of compliance. This was identified as a risk on the corporate risk register in 2014. A number of measures had been put into place to improve compliance, such as a monthly trust wide NICE guidance implementation committee. This reviewed current practice and developed action plans to ensure compliance with the latest NICE guidance.
- Patient assessments were based on national tools, such as the Malnutrition National Screening Tool (MUST) and the Braden scale for predicting pressure ulcer risk. Care pathways based on national guidance were in place for conditions such as sepsis, stroke and pressure ulcers.
- Services for children and young people met nine of the ten standards of the Royal College of Paediatrics and Child Health

Facing the Future 2015 guidelines. This included an admissions review by a paediatric doctor within four hours and by a paediatric consultant with 24 hours, daily consultant-led handovers and level three child protection training amongst all clinicians. The guidance recommends a consultant always be available at peak times. Although consultant rotas did not evidence this, all of the doctors we spoke with said consultants routinely stayed on site longer than their shift. This meant services met this recommendation in practice but could not provide evidence this was always the case.

- Staff showed us how they would access local guidelines on the trust intranet. Full time staff told us that clinical guidelines were easily accessible. We were told guidelines and pathways were available on a downloadable mobile phone application.
- However, agency staff in the ED did not have access to the computer terminals in the department which limited their access to trust protocols and guidelines. There was no other way to access guidelines.
- There were examples of recent local audits that had been completed across the organisation.
- We found documents for diagnostic imaging relating to the IR(ME)R and IRR99 regulations were held on the hospital's shared drive. The local rules for the hospital had not been updated since 2012. The procedures that all employers are required to have in place when using ionising radiation had also not been updated since 2012.

Patient outcomes

- The trust participated in a range of national audits so that it could benchmark its practice and performance against best practice and other hospitals.
- In the 2013/14 RCEM audit of severe sepsis and septic shock the ED at Queens Hospital department performed worse that than the England average in eight of the twelve indicators.
- Queen's hospital generally performed similar to the England average in the RCEM mental health in the ED audit. However, the department did not meet the fundamental standard that all patients should have a risk assessment taken and recorded in their clinical record.
- The unplanned re-attendance rate (number of patient re-attending within seven days of a previous attendance at A&E) for the ED 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%.

Summary of findings

- At Queen's Hospital, the standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures. This suggests that the hospital's care and discharge arrangements might be inappropriate. However, other factors could be involved, such as patients having other comorbidities (the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder) or poorly organised rehabilitation and support services when a patient is transferred home following treatment.
- At King George hospital, the standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate. However, for non-elective admissions, the standardised relative risk of readmission was higher, particularly for geriatric medicine.
- In the National Heart Failure Audit (2013/14), the hospital performed equal to, or better than, the England average in five out of 11 measures. However, the results showed no improvement from the previous year when measured against the England average, as it performed equal to or better on the same five measures overall.
- Queen's hospital High Acute Stroke Unit (HASU) saw a steady performance in the Sentinel Stroke National Audit Programme (SSNAP) from April 15 – December 15 with SSNAP level remaining at performance level 'B' (on an A-E rating scale, where A is the highest) across all quarters. However, January 16 – March 16 saw a decline in performance with SSNAP level dropping to level 'D'.
- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2015, Queen's hospital performed better than the England average in 13 out of the 21 audit measures. Significant improvements had been made in foot risk assessment since the previous audit. However, one of the measures where the hospital performed below the England average is where patients were not seen by the multidisciplinary foot team (MDFT) within 24 hours. King George Hospital scored better than the England average for nine indicators.
- In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures. Only 78.7% of patients were seen by a

nurse specialist (against an expected standard of 80%). Only 80.9% were discussed in a multidisciplinary team (MDT) meeting (against an expected standard of 95%). Only 64% received a pathological diagnosis (against an expected minimum standard of 75%). Action plans had been put into place to improve patient outcomes in this area. Further work was being done to introduce a nurse-led triage system and achieve cancer waiting time indicators.

- The organisation performed worse than the England average in the paediatric diabetes audit 2014/15 with 12% of patients having an HbA1c balance of less than 58 mmol/l compared with the national average of 22%. The mean HbA1c of patients was 3% worse than the England average. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time and hospitals benchmark their performance against NICE quality standard 6, which states that a HbA1c balanced of over 58 mmol/l indicates a poorly controlled diabetes.
- An IR(ME)R audit was last done in 2014. We saw that King George Hospital was not compliant with the audit. We did not see an updated action plan. The radiation protection advisor (RPA) told us the IR(ME)R procedures were being updated but these still currently showed a review date of 2012 on the electronic system.

Multi-disciplinary working and coordinated care pathways

- We observed good multidisciplinary (MDT) working across the trust. Most staff spoke positively about MDT working and we found evidence of good multidisciplinary relationships supporting patient care.
- We found that the ED's at both sites had a good working relationship with other hospital departments and noted that staff across the hospital acknowledged that the ED was a collective responsibility.
- We found evidence of good MDT working with external organisations such as primary care GP's, community safeguarding teams, the Police and ambulance services.
- The trust had introduced Schwartz rounds across both hospital sites to share working practices and increase support amongst staff of different disciplines. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke to had varying awareness of these sessions.

Seven day services

- Many teams worked normal office hours such as: speech and language therapists, occupational therapy and physiotherapy. However, the physiotherapy department provided an on-call service at the weekend.
- Pathology services were unable to provide an adequately staffed service outside of the core working hours of 9am to 5.30pm, Monday to Friday. Outside of these hours, existing staff provided a service on a voluntary rostered basis, which meant staffing was not always at establishment.
- The radiology service provided emergency cover 24 hours a day, seven days a week across CT, ultrasound, interventional radiology, and plain film imaging.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with had mixed knowledge of the principles of consent and mental capacity, including the treatment of patients with Deprivation of Liberty Safeguards (DoLS) orders and were not familiar with the term 'mental capacity.'
- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Advisor, who provided support and training to staff as necessary. We saw evidence that they regularly emailed senior staff to remind them of the key issues surrounding capacity, and provided additional training around topics such as independent mental capacity advocacy and the MCA itself. Training in relation to the Mental Capacity Act 2005 was incorporated into safeguarding training.

Are services at this trust caring?

We examined the caring domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

- The majority of patients were positive about the care they received and we observed courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Staff provided emotional support to patients and relatives and could signpost them to other support services if required.

However,

- We observed some negative interactions in the emergency department (ED) at Queens Hospital. We also observed a patient calling out for help and was ignored until we escalated to the nurse in charge.
- We found privacy curtains were not being drawn in the main diagnostic and imaging department and the emergency room in ophthalmology had bays that did not promote patients privacy and dignity.

Compassionate Care

- We saw that most staff demonstrated empathy and compassion towards patients. Staff introduced themselves to patients in a welcoming way and sought permission to enter their bed space.
- General observations confirmed staff respected the privacy and dignity of patients. In most areas we observed curtains being drawn around cubicles and blankets being offered to cover patients if required.
- The wards that we visited had a performance noticeboard on display which showed the most recent FFT scores. Most wards were scoring recommendation scores comparable to the England average of 96% (May 2016). However, the ED at both sites was slightly lower than the England average.
- However, we found the emergency room in ophthalmology did not promote patients privacy or dignity. The room had three bays separated by room dividers and curtains. The front area of the room was used as a patient triage area and there was also a screen in the area for conducting eye testing. Staff we spoke with acknowledged that the lay out of the room could compromise patients privacy and dignity, but said that space was an issue in the ophthalmology clinic.
- Positive interactions were not always demonstrated in the ED. For instance, we observed a patient ask a nurse if they could go to the toilet and the nurse responded in an unfriendly manner. We also observed a confused patient asking a doctor for help at the nurses station, who was responded to in an unfriendly and dismissive manner. The patient continued to ask for help and was ignored until a nurse came to help. We observed one patient shouting out for help numerous times and was ignored. We raised this with the nurse in charge who then attended to the patient.

Understanding and involvement of patients and those close to them

Summary of findings

- We found good evidence of clinical staff involving patients, and their relatives, in their care. Patients fed back that staff talked to them at an appropriate level of understanding and valued that staff listened to their views.
- We saw that the trust had implemented the use of 'you said, we did' boards in the ED at Queens Hospital which gave feedback on changes that were being made as a result of patient and relative feedback.
- Some patients and relatives on the King George site felt that more could be done to involve them in their care, especially surrounding discharge.

Emotional support

- We observed staff demonstrating an understanding of the emotional impact of the patients' condition during various interactions and observation. Feedback from patients and relatives was positive and they told us staff were supportive and had been reassuring.
- The chaplaincy service provided good support for patients and relatives. We heard that it was accessible and the team responded promptly when requested. Chaplains were representative of several major religions including Church of England, Baptist, Roman Catholic, Islam, Judaism, and Sikhism.
- There were two prayer rooms available at Queen's Hospital, with ablution facilities available in one of the multi-faith prayer rooms. The King George Hospital had a multi-faith prayer room that was open 24 hours a day.
- Psycho-oncology services and complementary therapies were available on-site, as well as alcohol liaison and counselling service for inpatients. However, nursing staff that we spoke with had not received any training specific to caring for patients with mental health conditions.

Are services at this trust responsive?

We examined the responsive domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

This was because:

- The percentage of patients being seen and treated within the emergency department (ED) recommended four hour timeframe at both hospital sites and the number of patients who left the department without being seen was worse than the national average.

Summary of findings

- The service was not meeting its 15 minutes triage standard for a high proportion of patients. The average time to triage was 28 minutes
- At the King George Hospital ED there was no viewing room where people could see their deceased relatives.
- In medical care at the King George Hospital patients were not always able to be located on the specialist ward appropriate for their condition. It was noted that management of these patients had improved since the previous inspection. However, the number of patients moved four or more times per admission had increased (although this may have been due to the trust incorrectly counting clinically appropriate moves within the hospital as ward moves). In some wards, bed moves were consistently occurring out of hours (between 10pm and 6am).
- Environments on some wards in the King George Hospital were not ideal, with high levels of noise and heat observed and reported. There was a lack of bedside televisions or radios across the wards, which some patients reported made them feel isolated and bored.
- The trust was consistently failing to meet NHS national indicators relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance. The trust was also not meeting 18-week indicators for non-urgent referral to treatment (RTT) times.
- Staff across in the King George Hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place. The specialist medicine division was currently working on an early discharge flow programme to address excessive lengths of stay.
- At the King George Hospital patient information leaflets were not available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
- The Patient Advice and Liaison Service (PALS) at the King George Hospital did not always respond to complaints in a timely manner.
- The percentage of appointments were cancelled by the hospital was 14% which is higher than the England average of 7.2%.

However,

Summary of findings

- The ED's at both sites worked closely with local GP's to stream patients effectively, including back to their own GP. A joint information booklet for parents had been developed to educate them around treatment for common childhood illnesses and injuries.
- There were a number of specialist teams available, including a frail and older persons advice and liaison team which worked closely with the ED departments.
- People living with dementia received tailored care and treatment. Care of the elderly wards at the King George Hospital had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help.
- Support for people with learning disabilities was available. There was a lead nurse available for support and advice. Staff made reasonable adjustments for patients with learning disabilities and there were easy read information leaflets available to explain treatments and support during their stay in hospital. There was a monthly safeguarding and learning disability operations group.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.
- Diagnostic waiting time indicators were met by the trust every month between May and August 2016.

Planning and delivering services which meet people's needs

- There were established links between the ED and with social care providers and local clinical commissioning groups (CCG).
- The trust had plans to go live on a child protection information sharing system by the end of October 2016. This was a national safeguarding database, which would help ensure better information sharing with the three local boroughs. Two of the local boroughs were already on the system and the trust were waiting for the final borough to go live before going live themselves.
- In recognition of the age profile of Havering being older than the London average, the trust had invested in the Frail and Older Persons Liaison Service (FOPAL), which regularly checked all patients 75 and above in the ED. The service did assessments on vulnerability using a frailty score and liaised with social services, family and local community services.

FOPAL initiated the Gold Standard framework assessment for patients who were through to benefit from the palliative care pathway. We saw one example of this and noted there had been discussion with the relatives.

- We found evidence of a local representatives panel. This was held bi-monthly, and included stakeholders such as Healthwatch and local councillors. Minutes indicated that service planning and delivery were a key component of the discussions within these meetings.
- There was a lack of bedside televisions or radios in the wards. Some patients without access to internet compatible devices told us that this made them feel isolated and bored.
- Work was in progress with the outpatients department to conduct a demand and capacity analysis in partnership with a private company that specialised in risk and trend analysis to develop a model whereby the hospital could assess and effectively manage the demands on the outpatients department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.

Meeting people's individual needs

- We found evidence in various areas where the trust had focused on developing services in response to patients' needs.
- Patients with a diagnosis of learning disability (LD) would be issued with a specific LD folder and were allocated an LD Link Nurse (a specialist nurse who supports people with a learning disability while they are in hospital, to make sure they get the care they need). Each patient would be issued with a hospital passport. Hospital passports were designed to give hospital staff helpful information, that was not only about illness and about health, but could also include a list of patient's likes and dislikes, favorite type of food and drink, as well as their interests.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.
- The trust hosted 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.
- At the King George Hospital we found the outpatient department had introduced new reception desks with a dip in

the desk, these made face to face interactions with reception staff accessible to wheelchair users. Separate waiting areas in the outpatients department had 'pods' to check patients into clinics on arrival.

- A multi-faith space was available to provide support in both hospitals. There was information for patients informing them how to access the multi-faith space if required.
- Within the catering menu there were many options to cater for those with different requirements. Menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options.
- However, patient information leaflets were not standardly available in languages other than English. Face-to-face and telephone translation services were available, although staff awareness of this was variable.
- During the second unannounced inspection of Queen's Hospital ED we noted the waiting areas were very full and there were few chairs available for patients. Within the paediatric waiting area we saw a number of parents standing with their children due to a lack of seating space.

Dementia

- The trust had implemented the use of blue and white butterfly symbols on patient information boards to indicate whether a patient had a diagnosis of dementia or delirium respectively. Patients living with dementia were nursed according to a specially designed care pathway and were offered 1:1 nursing care from healthcare assistants with enhanced training, who provided stimulation and company.
- Family members and carers were encouraged to be involved in their care. 'This is me' booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient. Red trays at meal times were used to alert nursing staff the patient may require extra help.
- Staff had received in-house training on caring for people living with dementia. All staff we spoke with were aware that these patients needed extra support and were able to describe how they would provide them with person-centred care. A specialist dementia team and dementia link nurses were available for support and advice.
- Staff used a cognitive assessment tool to identify patients with memory issues on admission. A joint delirium clinic with a psychiatrist from another trust also took place at the Queen's site to enable the rapid assessment of patients who had recently become confused.

- There were dementia carers and relatives coffee mornings, provided by the dementia team on a monthly basis. The purpose of these coffee mornings was to provide information and support to carers and relatives of patients living with dementia.

Access and flow

- Queen's Hospital March 2015 inspection report highlighted that in the past there been long waiting times for the majority of patients who attended the ED.
- Standards set by the government state that 95% of patients who attend the ED should be admitted or discharged within four hours. The percentage of patients seen within 4 hours at both hospitals had deteriorated over time rarely met the national standard.
- A 'streaming' process had been introduced (a process designed to fast track patients to the right places from reception, such as UCC, GPs or majors). The purpose of this was to prevent people waiting in the ED when it might not be required and minimise overcrowding.
- We saw the trust had developed ED escalation plans (full capacity protocols). These set out clear pathways and processes to be followed when there was a failure to deliver patient flow through the department as usual.
- We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed decision making impacted on patient care.
- The risk register in medicine highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards. This was causing poor patient experience, poor clinical outcomes, as well as poor patient flow throughout the division. The trust target of 40% of patients to be discharged between 8am and 12pm was not being achieved in the year September 2015 to August 2016.
- The trust did not submit any referral to treatment time (RTT) data to NHS England in the reporting period (Jun 2015 – May 2016). We were informed that this was due to the 52 week waiting times and the RTT Patient Tracking List (PLT) was undergoing a process of validation.
- In April 2016 the deputy chief operating officer (COO) had joined the hospital and had conducted an analysis of patients that had waited for an appointment for over 52 weeks. As a result

the hospital identified that a further 6000 appointments were required to provide these patients with care and treatment. An action plan and timescales were in place as a result of the analysis.

- The medical director told us the challenge for the trust in regards to RTT was patients waiting 18 to 52 weeks. The medical director said there had been a number of discussions with the COO in regards to patient safety whilst patients waited for an appointment and we were shown evidence that these had been assessed for clinical risk.
- The hospital had introduced initiatives to reduce patients RTT, including reviewing patients arriving in the emergency department (ED) to establish if the presenting problem was related to an outpatient's department appointment.
- In addition, the hospital was using a range of private providers to assist in clearing the backlog of appointments. The deputy COO told us the hospital looked daily at patients referred to a private provider and tracked and monitored their care and treatment. The hospital met with providers weekly and identified where patients were on their care and treatment journey. The hospital was also monitoring patient outcomes within private care provision.
- Senior managers told us the hospital was on-track to clear the backlog of patients waiting over 52 weeks for an appointment by the end of September 2016.
- The RTT performance pack dated 1 September 2016 recorded there had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016. The trust had analysed the trajectory for these patients and were 387 appointments ahead of the planned target.
- In the trust's annual report 2015/16, they reported that 96.1% of patients with a diagnosis of cancer received their first treatment within 31 days of decision to treat (against a standard of 96%). In 2016, performance against the 31-day waiting time indicator continued to be good, achieving 100% for every month between March and July, apart from in April, when only 83.4% of patients were seen.
- In the same annual report, the trust reported that only 74% of patients were receiving their first treatment from the initial GP referral within 62 days (against a national standard of 85%). This continued to be an issue in 2016, with between only 25% and 80% of patients meeting the 62-day waiting time indicator between March and July. The trust was aware that it was failing to achieve this waiting time indicator and attributed this to

poor pathway management for specific tumour groups (urology, upper GI and colorectal), capacity and workforce issues, in addition to diagnostic tests occurring too late in the pathways.

- An action plan was devised to improve this, which included the engagement with partners via the London Cancer Vanguard programme to escalate issues and delays, regular review of capacity with additional clinics being run regularly and a recruitment plan being put into place. A cancer programme board monitored performance on a weekly basis and strengthened tracking of all patients on a 62-day pathway.
- The percentage of patients who did not attend (DNA) their appointment was 9.0%; this was above the England average of 6.8%. Managers said they recognised that the DNA rate was too high. The hospital had introduced an initiative whereby patients would not be discharged following their first missed appointment; they would instead be given three weeks' notice.

Learning from complaints and concerns

- We found that there was a culture of openness around complaints in the trust.
- Staff we spoke with confirmed awareness of the trust complaints procedure. However, not all were able to provide examples of complaints or concerns that resulted in change of practice or demonstrate how they learnt from it.
- Patient information on how to make a complaint or raise a concern with Patient Advice and Liaison Service (PALS) was available throughout the department.
- In most clinical areas that we visited, there was a 'good to talk' board, which included information on how to contact the patient advice and liaison service (PALS), language services, chaplaincy support and how to provide informal feedback. There were also boards on every ward that explained who different key staff were and included pictures of the different staff uniforms in use, explaining what role each one signified.
- Minutes from clinical quality review meetings indicated that PALS responses to complaints were sometimes not timely. Between April and June 2016, only 60% of complaints were replied to within the timescale agreed with the complainant, against a trust target of 85%.
- Complaints data was discussed monthly at both the clinical quality review meeting and the patient experience and engagement group. Any themes or learning were then shared with wider staff groups through the integrated quality and safety report, team meetings and divisional newsletters.

Summary of findings

Are services at this trust well-led?

Requires improvement

We rated the well led domain as requires improvement. This was because:

- There was a lack of clarity on clinical strategy at a service level. We were told plans for the ED's were often changing and staff were not able to talk about local plans. Similarly in outpatient services staff were not able to articulate the future clinical strategy for services.
- We found inconsistency in the application of infection prevention and control policies and procedures.
- We found that whilst improvements had been made in regards to governance structures, this was not mature or embedded and there were a number of clinical policies and national guidelines which were out of date, or in some areas where we found multiple clinical guidelines available to staff.

However,

- Senior Leadership was visible and involved in clinical activity. Staff were positive about changes and were starting to feel more optimistic.
- Staff told us that the executive board frequently visited the various hospital departments interacting with staff and patients.
- Staff knew and understood the vision of the trust.
- Resources had been invested into improving clinical governance structures and risk management since the past inspection in March 2015. An external organisation had worked with the trust on strengthening their governance structures. The trust had rebranded clinical governance as 'quality and safety' and meetings took place on a monthly basis.
- It was evident that risk management was a priority at departmental level and local risk registers were more robust than during previous inspections.
- Quality improvement and research projects took place that drove innovation and improved the patient experience.

Leadership of this trust

- At the time of inspection, the senior leadership team comprised of substantive executives and non-executives. The Chair of the organisation Maureen Dalziel, had been in post since 2014 and the Chief Executive Officer Matthew Hopkins had been in post since April 2014.
- All non-executive director's had been in post for over two years. Whilst the executive director team including the chief operating office, the director of finance and investment, the director of people and organisational development and director of

strategy and planning in post from 2014. The medical director joined the organisation in 2015 and the most recent appointment the chief nurse had been in post since January 2016.

- The organisation operated across six clinical divisions: acute medicine, specialist medicine, surgery, anaesthetics, women and children's and cancer and clinical support. Each clinical division ran a divisional operational board, a divisional recruitment and retention group, a divisional quality and safety group. These were supported by speciality / service quality and safety groups and ward / team meetings. Each division consisting of a divisional leadership team, led by a clinical divisional director and supported by a divisional manager and a divisional nurse in a triumvirate model of management.

Vision and strategy

- In 2014 the organisation had developed the the trust values of Passion, Responsibility, Innovation, Drive and Empowerment (PRIDE). These values were discussed during the trust induction and staff were able to talk about these values during our inspection. We observed staff carrying a 'pocket-sized' booklet with the trust's values attached to their lanyards.
- The five strategic priorities for 2015/16 were:

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

- The approach of continuous, incremental improvement was emphasised across all of these areas. The focus for all improvement work within the trust was the elimination of waste, the standardisation of work, mistake proofing and a methodology aimed primarily at reducing flow times and response times to patients. The goal of the trust was to become a learning organisation that engaged staff at every level. As such, this approach had been incorporated into the staff appraisal process.
- There was a five-year plan which had been developed in partnership with system leaders and organisations across north east London (with 2016/17 being the first year of the plan). This plan described how services would collectively work to deliver sustainable services to the local population, and was aligned to the emerging trust clinical services strategy. The plan involved working closely with commissioners to define and manage

clinical pathways. In December 2015, the trust had conducted a stakeholder audit to identify strengths and weaknesses and find a way of working together with other organisations to improve services.

Governance, risk management and quality measurement

- The trust had commissioned an external organisation to assist the set-up of governance systems and processes. There was a substantial drive across the organisation to improve quality of the service through a consistent clinical governance practices, however we found evidence that the pillars of governance were not fully matured and embedded at the time of our inspection.
- Each clinical division held a monthly quality and governance meetings which were used to ensure learning from incidents and complaints were embedded into the practice. We noted from minutes of these meetings that complaints, incidents and emerging risks were discussed, evaluated and monitored.
- Divisional board meetings and divisional quality and governance meetings fed into the trust-wide governance and quality structure for executive and non-executive review and sign-off, where appropriate.
- Structures to maintain risk management existed and divisional leaders understood these systems. We reviewed the risk registers for the divisions that we inspected. In the main these captured the majority of risks that we expected. However, we noted he organisation had recognised that further work was required to ensure the divisions were in control of their risks.
- There were several groups which aimed to improve governance and risk management across the trust. The clinical outcome and effectiveness group discussed topics such as national targets, audits, care pathways, medicine optimisation and NICE compliance. The patient safety group focused on topics such as incidents, infection prevention and control, medicines safety and safeguarding. The patient experience group discussed areas such as complaints, dementia, nutrition and volunteering. The people and culture committee examined issues such as staffing, training and equality and diversity. Discussions from these meetings all fed into the monthly quality assurance committee, which considered governance and risk management issues as a whole. However, some staff told us that this committee was often poorly attended.
- There were also regular senior nurses meetings, as well as divisional and ward meetings where risk and governance issues were discussed with a wider staff group. The frequency of these meetings varied across divisions, with some specialties or wards meeting every two weeks, and some every three months.

- 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, and although some told us that this increased their workload, they could see how resulting information was shared amongst teams to promote improvement. There was an audit committee that met five times a year to oversee both external and internal audits.
- The hospital had introduced a 'performance pack' suite of reports that provided information on RTT performance. The deputy COO told us the reports provided the hospital with "clear visibility and accountability" with the aim of reducing the number of patients waiting for over 52 weeks for their care and treatment.
- The trust's medical director told us the trust had established harm panels which reviewed the admitted patients' pathway to assess degrees of patient harm. Three minor harms had been identified as a result of the review. The trust had also sampled 10% of non-admitted patients and identified no harm to patients with the longest waits. The assistant medical director had continued to review patients via 'dip checks.'
- There was some misalignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'. For example in the ED at Queens Hospital nursing staffing levels was raised consistently by staff but this was not on the divisions risk register. However, we noted in some of the safety and quality minutes from April 2016 that "workforce vacancy impacting on patient safety – nursing" was recorded as an amber risk. However, we could not find this on the risk register provided by the trust.
- Trust policies were reviewed via the Policy Approval Group, however we were informed that this committee had been suspended and reinstated very recently. We found a number of out of date clinical policies during our inspection. We also found multiple versions of policies available on the trust intranet which could lead to staff confusion.

Culture within the trust

- Most staff that we spoke with talked openly about the culture within the trust. A number of staff told us they felt more positive and that morale was improving.
- Staff described the chief executive officer as having an open door policy allowing staff to make their thoughts and opinions known.

- Staff consistently told us of their commitment to provide person-centred care, and spoke positively about the care they delivered. Staff understood their responsibility in putting patients first and incorporating the trust's values into caring for patients.
- Most staff we spoke with commented on how supportive staff of all levels were, and how the trust had become a better organisation to work in.
- Nurses told us there had been a shift away from 'blame culture', towards learning from mistakes and 'near misses'. Most felt comfortable to raise concerns with local managers, but were also aware of formal whistleblowing procedures and policy. The independent guardian service was now into its third year and helped staff to openly raise their concerns in confidence.
- Staff commented on improvements in nursing morale and empowerment, making the wards more enjoyable to work on and reducing stress and sickness.

Equalities and Diversity – including Workforce Race Equality Standard

- The Workforce Race Equality Standard (WRES) became mandated in the NHS Standard Contract 2015/16 and commissioning contracts. As a result NHS bodies were required to publish a WRES baseline report by 1st July 2015, based on a set of WRES indicators at April 2015. There are nine WRES indicators (refer to Appendix 1) of which four relate to workforce data; another four are based on questions from the NHS staff survey questions and one indicator relates to improving the ethnic composition of NHS Boards, better to reflect the population served. NHS bodies are required to produce WRES reports annually and demonstrate progress against these indicators of workforce race equality.
- As part of our inspection we held one Black, Asian, and minority ethnic (BME) staff focus group at Queens Hospital and also an interview with the Head of Inclusion (the Trust Equality and Diversity Lead).
- Generally BME staff thought working for the Trust good, but some raised concerns that there was not much opportunity for progression and that there was a lack of BME role models at senior levels of the organisation.
- We found evidence of WRES reports being discussed at board level. We found that a BME network was recently created and that the network is engaging with the newly implemented Inclusion Steering Group.
- The trust now has a culture of openness and a willingness to engage with its BME staff, the BME workforce via its BME

network has expressed confidence in the trust and a willingness to work with the organisation to improve the experience of its minority staff. It was considered that the trust could engage with its BME workforce in a more meaningful way through assigning more specific goals to its' trust-wide action plan.

Fit and Proper Persons

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The regulation came in to force in November 2014.
- The trust had a fit and proper persons policy in place. This was a policy covering arrangements for both recruitment and ongoing assurance. The Fit and Proper Person's criteria were linked to the annual appraisals of executive Board Directors, to ensure ongoing compliance.

Public engagement

- The trust had appointed a Director of communications and marketing to work with the Board, as well as holding responsibilities for external communications. The trust encouraged a number of initiatives to foster external engagement including: 'you said, we did' boards and developing ED twitter feeds.
- The trust had also introduced a patient experience and engagement group in 2015, which provided a forum for staff to engage with and receive feedback from key stakeholders including patients and carers. Listening events, held in conjunction with Healthwatch, focused on the highest number of Patient Advice and Liaison Service (PALS) enquiries and formal complaints, allowed patients the chance to ask senior management questions around issues raised. The trust produced leaflets that summarised concerns arising from these meetings and stated what had been done to address these.
- The trust included patient stories as part of the corporate trust induction. A patient story, based on real life experiences from the hospital, was presented each month at the board meetings so that leaders could hear first-hand about how patients felt about the care they had received.

Staff engagement

- The executive directors and non-executive directors carried out walk-arounds, during which they visit a range of clinical areas and receive staff feedback.

Summary of findings

- Feedback from patients was obtained from the NHS Friends and Family test. We found evidence of other local surveys to obtain further feedback from staff. In the 2015 staff survey 2092 staff at Barking, Havering and Redbridge University Hospitals NHS Trust took part in the National NHS staff survey. This was a response rate of 37% which was below an overall average response rate of 41% for acute trusts in England, but represented an increased response of 4% on the 2014 staff survey.
- We looked at overall trust results of feedback from staff in the 2015 National NHS staff survey which was combined for King George hospital and Queen's hospital. The trust scored better than the national average for staff motivation at work, quality of non-mandatory training, percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months, percentage of staff reporting errors, near misses or incidents witnessed in the last month and effective use of patient feedback.
- However, the trust scored below the national average for percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, percentage of staff satisfied with the opportunities for flexible working patterns, percentage of staff experiencing discrimination at work in last 12 months, percentage of staff suffering work related stress in last 12 months and percentage of staff working extra hours.
- The trust celebrated the achievements of staff by having a 'star of the month' which colleagues nominated. There were also annual staff award ceremonies, based around the trust values, which awarded staff in categories such as 'Hospital Hero', 'Working Together' and 'Pursuing Excellence'.
- A 'terrific ticket' initiative had been introduced across the trust, which rewarded staff members for good practice and for those who went over and beyond in their line of work
- The trust implemented a training programme for Health Care Assistants (HCAs), whereby staff work to achieve a Care Certificate. We were informed that 92% of HCAs had completed this course at the time of our inspection and that this was one area of focus in raising the profile of nursing within the organisation.

Innovation, improvement and sustainability

Summary of findings

- The trust had been recognised with a number of awards over the twelve months prior to our inspection. The Healthy Workplace Charter was awarded in recognition of trust Health and Wellbeing Team and of the resources dedicated to ensuring a healthier workplace.
- The initiatives implemented include encouraging healthy eating and exercise, offering healthier food choices through catering at the hospitals, and encouraging attendance at various exercise or wellbeing classes on site.
- Two of our consultants were recognised for their commitment to helping junior colleagues in their training and development. One consultant was awarded the Outstanding Clinician Achievement award by the Essex Medical Society. Whilst another was the winner in the first Postgraduate Medical and Dental Education awards, in the Clinical Supervisor of the Year category.
- The action the trust had taken to reduce carbon emissions and tackle climate change had won a number of awards including: the Public Sector Sustainability Awards – Winner, Most Sustainable Public Sector Organisation. The Green Apple Awards – Winner, Environment Best Practice; and the Green Essex Awards – Winner, Greenest Large Business
- The trust was chosen as one of five trusts in the country to be mentored by the US system leader in sustainable change (the USA's 'Hospital of the Decade') as part of a five-year improvement programme. Clinicians and leaders from the institute were teaching staff about the principles and systems that they used. The trust values were a locally branded adaptation of their change methodology and formed the basis of their new change management approach.
- The trust engaged with the University of East London to develop a training pathway in health and social care for school leavers, as well as developing other innovative roles such as nursing associates to create openings for local recruitment in nursing.
- The organisation had encouraged a number of local innovations which have benefited patients including: the ehandover system. The trust is currently working with a private enterprise company to promote innovation, and will be holding regular events to encourage our staff in innovation.

Overview of ratings

Our ratings for Queens Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good

Our ratings for The King George Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Good	Requires improvement

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

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to m ake their stay in hospital easier and reduce any emotional distress.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which significantly improved the quality of life for families.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

Areas for improvement

Action the trust MUST take to improve

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

Importantly, the trust must:

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

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve paediatric nursing capacity.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores.
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes.

Outstanding practice and areas for improvement

- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Review out-of-hours provision of services and consider how to more effectively provide a truly seven day service.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.
- Make patient information leaflets readily available to those whose first language is not English.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average.
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- There is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.
- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance We had concerns around the governance of the emergency department including the handling of investigations of incidents, risk management, oversight of resuscitation training, and infection prevention and control management. The service must address this including: 1. Taking action to improve levels of resuscitation training. 2. Ensure there is oversight of the training competencies of locum doctors, particularly around advanced life support training. 3. Take action to improve the response to patients with suspected sepsis. 4. Take action to improve poor levels of hand hygiene compliance. This was a breach of Regulation 17(2)(a) and 17(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment. We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment There was inadequate compliance with fire safety standards and staff did not have sufficient understanding of local fire safety procedures. Environmental safety management was inconsistent for children's services. This included unsecured areas used to store items that could be dangerous to children, including sharps bins, chlorine tablets and clinical equipment. These concerns must be addressed, including: 1. Ensuring fire safety is maintained by ensuring fire doors are not forced to remain open and fire safety standards are appropriately implemented. 2. Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment. 3. Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities. This was a breach of Regulation 15(1)(a) and 15(1)(d)

decision making impacted on patient care. The percentage of patients who left without being seen was also higher than the England average in all months between January 2016 and August 2016.

1. Ensure all patients attending the ED are seen more quickly by a clinician.

This was a breach of Regulation 12(2)(a).